Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

APRIL 1961

WHEN ARE PATIENTS NEGLIGENT?
P. 62

Books for Boards
pg. 98

I PASSED THE ECFMG EXAM, *But . . .*
P. 78

8 MORE CONTEST WINNERS!
pg. 69

In a series of 24 handicapped arthritics treated with dexamethasone for 8 to 16 months, ring size decreased consistently—objective evidence of antirheumatic effects which were maintained throughout the entire period of observation. Improvement was also noted in other antirheumatic indices, i. e., pain on motion, tenderness, swelling and morning stiffness.[1]

Supplied: as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate and new Elixir DECADRON. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

Reference: 1. Bunim, J. J., in Hollander, J. L.: Arthritis and Allied Conditions, ed. 6, Philadelphia, Lea & Febiger, 1960, p. 364.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.

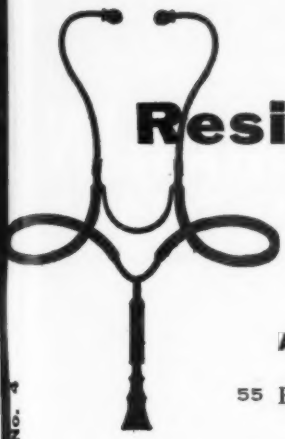
Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

April 1961, Vol. 7, No. 4

CONTENTS



Resident Physician

Articles

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April 1961, Vol. 7, No. 4

PRE & POST-OP

in every type of surgery

"PREMARIN" INTRAVENOUS

the physiologic hemostat

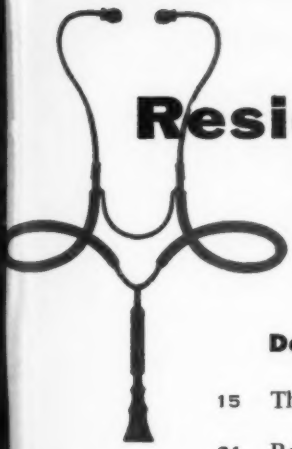
CONTROLS BLEEDING EFFICIENTLY AND SAFELY

The definite value of "PREMARIN" INTRAVENOUS in clearing the operative field, minimizing blood loss, and preventing postoperative hemorrhage is being consistently reported in patients undergoing ophthalmologic, EENT, Ob-Gyn., urologic, and oral surgery.[2] The wide range of application for "PREMARIN" INTRAVENOUS also includes spontaneous hemorrhage (epistaxis, gastrointestinal bleeding, etc.) as well as bleeding during and after surgery.

Over 1,000,000 injections have been given to date without a single report of toxicity.

PREMARIN® INTRAVENOUS (conjugated estrogens, equine) is supplied in packages containing one "Secule"® providing 20 mg., and one 5 cc. vial sterile diluent with 0.5% phenol U.S.P. (Dosage may be administered intramuscularly to small children.)

1. Johnson, J. F.: Paper presented at Symposium on Blood, Wayne State University, Detroit, Michigan, Jan. 18, 1957; cited in M. Science **1**:33 (Mar. 25) 1957; Proc. Soc. Exper. Biol. & Med. **94**:92 (Jan.) 1957.
2. Published and unpublished case reports, Ayerst Laboratories.
3. Rigg, J. P.: Digest Ophth. & Otolaryng. **20**:28 (Nov.) 1957.
4. Rigual, R.: Ibid., p. 3. 5. Servoss, H. M., and Shapiro, F.: Ibid., p. 10. 6. Menger, H. C.: J.A.M.A. **159**:546 (Oct. 8) 1955.



Resident Physician

Departments

April 1961, Vol. 7, No. 4

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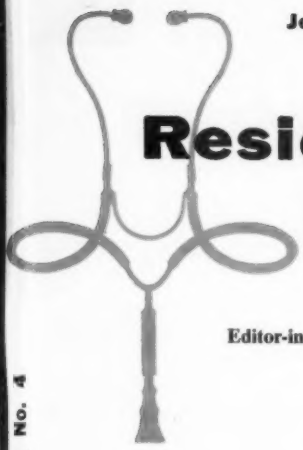
Journal for the Hospital Staff Officer

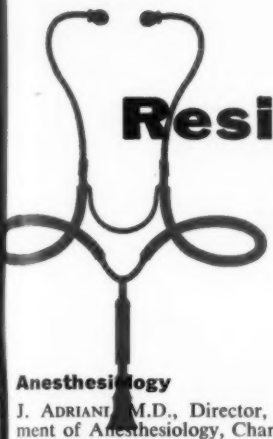


Resident Physician

April 1961, Vol. 7, No. 4

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

Subscription rate $10.00 per year. Single copies $1.00. Notify publisher promptly of change of address.



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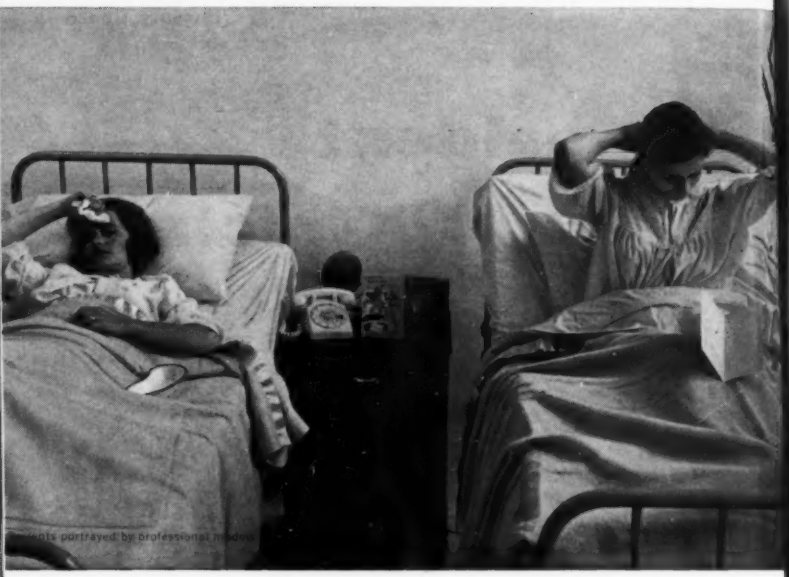
HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.

a pair of gynecologic patients:



both are free of pain—but only one is on

DILAUDID.

(Dihydromorphinone HCl)

swift, sure analgesia normally unmarred by nausea and vomiting

DILAUDID provides unexcelled analgesia before and after gynecologic, obstetric and surgical procedures. Its high therapeutic ratio is commonly reflected by lack of nausea and vomiting — and marked freedom from dizziness, somnolence, anorexia and constipation.

▲ by mouth ▲ by needle ▲ by rectum

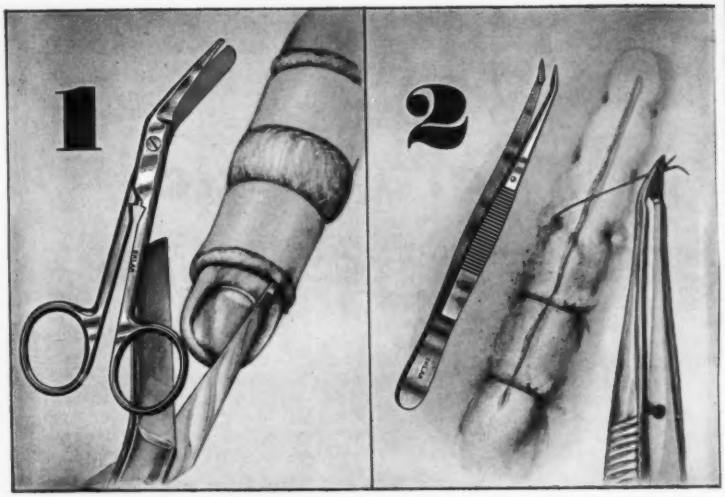
2 mg., 3 mg., and 4 mg.

May be habit forming—usual precautions should be observed as with other opiate analgesics.

KNOLL PHARMACEUTICAL COMPANY • ORANGE, NEW JERSEY

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk (*).



specifically designed for the purpose

1 Burnham Finger Bandage Scissors

Minimizes pain caused by conventional acorn tip ...thin lower blade with rounded tip slips easily under bandage... notched shank facilitates ready removal of needles frozen to syringes...provides leverage to shear through heavy dressings — yet compact and light enough for the pocket.

2 Healy Suture Removing Forceps

Superior to anatomic forceps for suture removal... broad triangular shaped jaws... roughened inner surfaces grip and hold the suture for cutting...precisely aligned, pointed tips permit gentle teasing out of suture ends that have retracted under the skin or become encrusted with exudate.

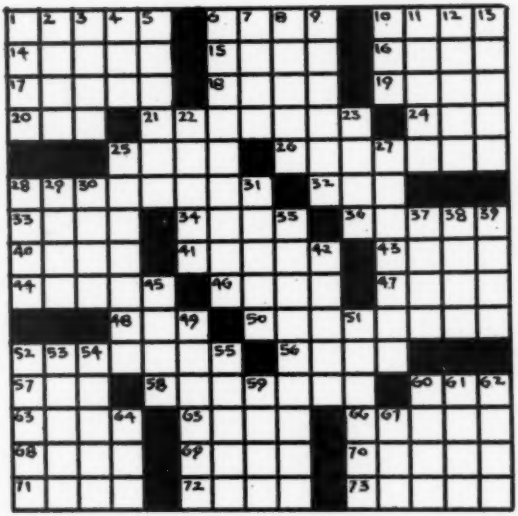
SKLAR PRODUCTS

Both instruments precision made of stainless steel by SKLAR, Long Island City, N.Y.

Available through accredited surgical supply dealers.

Resident Relaxer

(Solution on page 170)

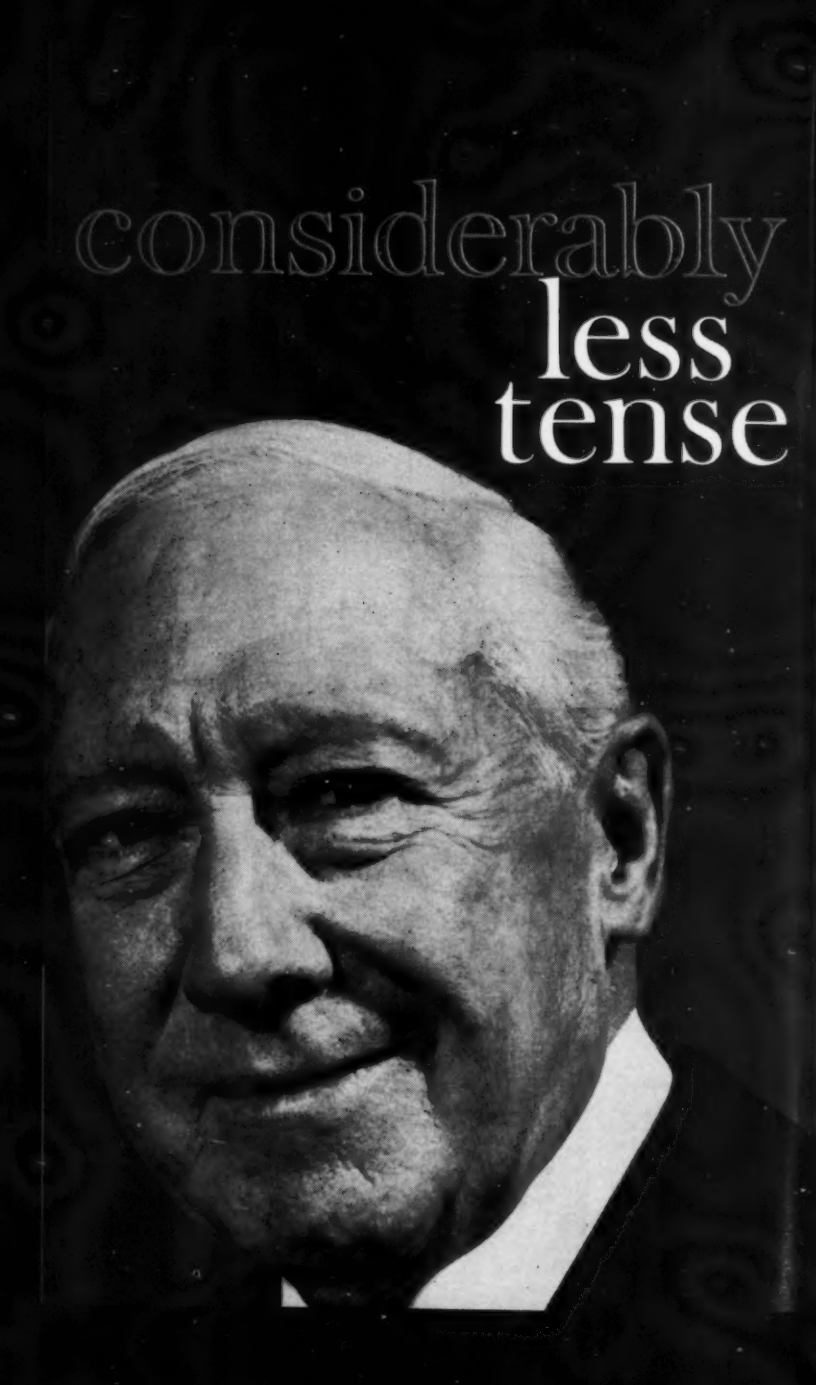


ACROSS

1. Childbirth
6. Animal upon which another organism lives parasitically
10. A matron
14. Excessively fat
15. An Arabian chieftain
16. Love (Lat.)
17. To lose blood
18. Methyl, sodium (symbols)
19. Test object in the ophthalmometer
20. Ever (poet.)
21. Any tumor of the gums
24. Physician (slang)
25. Native of Scotland
26. Renowned
28. An imprudent person (colloq.)
32. Period of time
33. A sea eagle
34. The spinal column (pl.)
36. Prefix indicating presence of nitryl in a compound
40. Restrain
41. Enclosures for skating
43. Wax impression
44. A flower
46. Cobalt, iodine, argon (symbols)
47. Identical
48. Reticulo-endothelial system (abbr.)
50. Presence of sodium in the blood
52. Accumulation of pus in the pleural cavity
56. A toothed wheel
57. A unit of velocity
58. Person weak-minded from old age (pl.)
60. Foot (comb. form)
63. A cauda
66. Profound unconsciousness
67. Gray with age
68. Toward the lee
69. Crest of a hill
70. Synthetic drug used in malaria treatment
71. To cause subsidence of symptoms of an acute disease
72. Man's name
73. Faculty of perceiving any stimulus

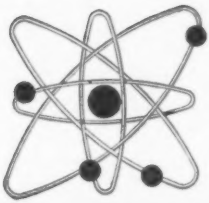
DOWN

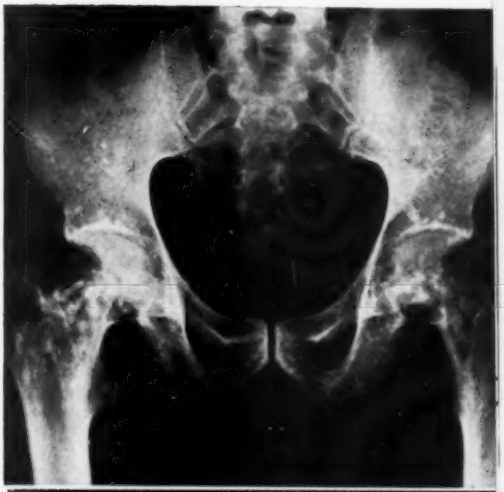
1. Part of an organ demarcated by fissures
2. Capable of
3. A fermented beverage
4. Suffix often indicating a carbohydrate
5. Take off weight
6. Causing blood-poisoning
7. A foreboding
8. Because
9. An injury or wound
10. Sheet rubber used in surgery
11. A substance derived from ammonia
12. A feebleminded person
13. Upright
22. Pertaining to a lobe
23. Objective evidence of a disease
25. Landscape
27. Discoverer of the gonococcus
28. The clear liquid which separates in the clotting of blood (pl.)
29. Greek god of war
30. A single thing
31. An inert gaseous element
35. An x-ray photograph
37. A group of players
38. Branch of a nerve or blood vessel (pl.)
39. Oil (Lat., pl.)
42. Surfeited
45. Discoverer of the cause of yellow fever
49. Artist's garment (pl.)
51. Skin eruptions
52. External
53. Floury
54. Practices diligently
55. Make amends
59. Americium, astatine (symbols)
60. Suffering
61. Son of Aphrodite
62. Unit of force, in physics
64. A sheltered place
67. Mined metal


considerably
less
tense

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center



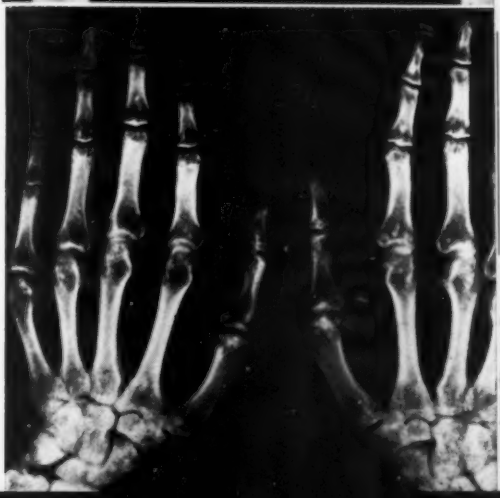


Thirty-year-old male.
Chief Complaint:
Pain in left hip
following auto accident.

Which Is Your Diagnosis?

1. Osteopoikilosis
2. Metastatic malignancy
3. Multiple infarctions
4. Osteogenesis imperfecta

(Answer on page 170)



"It's about time someone developed a good analgesic that controls pain and also allows the patient to stay awake and cooperate better with the nursing staff."

"It's about time we had an anal
that doesn't keep postoperative
patients knocked out. I'd like t
see them awake after operatio
I'd worry less about hypostati
pneumonia and venous stasis."

Alvodine

ethanesulfon

Brand of piminodine ethanesulfonate

Alvodine is the first narcotic analgesic that provi
practically "pure" analgesia. It relieves pain with
causing drowsiness (93.7 per cent of 1577 patien
or significant euphoria (99.2 per cent). When sl
follows the administration of Alvodine, it is due
relief of pain, not to hypnosis. In therapeutic dosa
Alvodine is safer than morphine because it has li
effect on respiration and circulation. Nausea and v
iting are rare following its use. Unlike codeine

Letters to the Editor

Immigrant and ECFMG

As I have understood in connection with the ECFMG, it is to raise the standard of the American Hospitals and to attain a better care for American patients. And also to dump all the undesirable foreign medical graduates, which is being done by the directorship of Dr. Smiley.

The purpose of this letter is to ask you if a foreign medical graduate who has an immigrant visa can be allowed to work in an American Hospital without taking the ECFMG examination? This particular graduate is from Peru.

Also this doctor has never

—Continued on page 42

When there's a pram in her future

You pleased her before, when you confirmed her hopes. You'll please her again when she takes her first Pramilet. She'll find that here's a vitamin-mineral prenatal supplement easy to swallow, attractive and (joy!) just one-per-day the usual dose.

Though she won't know it, she'll owe part of her appreciation to Pramilets' unique Filmtab coating. It makes each tablet smaller and daintier than ever possible with a sugar coating. It seals in taste and odor, too. And of course, she'll like the graceful 100-Filmtab bottle that goes so well on dresser top or dining table.

More important from your own viewpoint, however, is the fine Pramilets formula. Seven minerals, nine vitamins. Its calcium is phosphorus-free. Its iron is in the well-tolerated form of ferrous fumarate. Its vitamins are all ample in terms of minimum daily requirements for pregnant women.

Your Abbott man will be glad to furnish details. Or literature will be promptly sent on your request. Just write to us at Abbott Laboratories, North Chicago, Illinois.

recommend Filmtab® PRAMILETS®

or (on prescription only, with folic acid) **PRAMILETS-F**

ABBOTT

FILMTAB—FILM-SEALED TABLETS, ABBOTT.

104215

—*Continued from page 37*

worked in an American hospital, never had an internship in USA. He was hired as resident right away! (His hospital is approved for G.P. residency and no internship.)

To be fair for those foreign graduates who have not passed the exam last September and are to be kicked out, I would appreciate it if you could tell me what the rule is pertaining to this matter. R.T.L., M.D.

(Name withheld at author's request)

• *Unless the doctor is licensed to practice medicine in the state, he must pass the ECFMG exam to remain on the resident staff.*

Tax Questions

Would you permit a question prompted by your article on Convention Expenses in the January 1961 issue of RESIDENT PHYSICIAN?

I recently went to a medical convention in Chicago the expenses for which are routinely deductible. However, instead of staying at the hotel where it was held, I stayed at the home of a brother.

I have been told that unless I would have a receipted hotel bill for the same dates as the meeting, the internal revenue examiner might question this expense and not allow it. What is your opinion? H.S., M.D.

DETROIT, MICHIGAN

I would appreciate very much if I could have your kind information regarding income tax. I am a permanent resident in U.S.A. on immigrant visa and a resident in pathology in Mount Sinai Hospital, Chicago. Last year I spent an important amount for transportation from New Jersey where I had a residency to Chicago for my present residency. Also I had expenses for the medical books, fees for ECFMG examination, English courses at the University for State Board Examination in New York, and some private medical courses for State Board in New York.

I would like to know if I can deduct all or some of these expenses and which form I have to use. My annual income is less than $5,000. F.E., M.D.

CHICAGO, ILLINOIS

• *Your letters have been referred to our tax adviser. You will hear from him directly. Other house staffers may direct questions to: Tax Clinic,* RESIDENT PHYSICIAN, 1447 Northern Blvd., Manhasset, N. Y.

—*Continued on page 45*

– *Continued from page 42*

New Orleans Car Costs

As I will be finishing my residency in Orthopedics this July and intend to enter practice at that time, your article "Should You Lease an Automobile?" in the November 1960 issue interested me very much.

However, after several inquiries, I feel I should let you know of the real facts and figures.

I inquired about "inexpensive" models with minimal accessories that I felt would be of definite benefit in this city and climate—i.e., heater, automatic transmission, and air conditioning. The quoted price before bargaining and without trade was $2545 on a 1961 Ford 2 door 8 cylinder. As we have a 3% sales tax, the price would be increased by about $75 or a total sales price of $2620. This figure is fairly close to the $2575 quoted in your article. I have not checked financing but utilizing your figure of $206 and adding to it for a very low down payment, I arrived at a figure of $300 for interest.

Repair costs are the same as in your article, i.e., $300 for two years. Complete insurance coverage as specified would not be more than $460 for two years in New Orleans as opposed to the $701 quoted. Finally license plates here are only $3 per year —thus a total of $6 for two years. Adding all of this together we get a total of $3686 from which we deduct $1000 value of the car at the end of the two years so that the actual cost for two years is $2686 or approximately $1343 per year.

After figuring this I asked about leasing this same car for 24 months. The monthly charge was $110 which included license plates and collision and comprehensive insurance. It did not cover liability insurance. If we figure liability as slightly less than one half the total insurance cost quoted above, then we can add $200 to the two-year cost. The total for leasing then becomes $2840 for two years or $1420 per year.

I would assume from this investigation, one of two things, either the figures quoted in the article are wrong or that the company leasing the car in the article is losing money. According to my figures it would cost almost $200 less to own than to lease for two years and this could undoubtedly be improved by bargaining at the time of buying the car.

Richard M. Levy, M.D.
CHARITY HOSPITAL OF LOUISIANA
NEW ORLEANS, LOUISIANA

—Concluded on page 50

will you help the mailman, your hospital and us?

Are you planning to move soon?

If so, will you please take a few seconds now* to fill out and mail the form below and help us in our efforts to have RESIDENT PHYSICIAN reach you promptly at your new hospital address?

* Please do it now — it will take us 30 days to process your change of address.

MAIL TO: RESIDENT PHYSICIAN, 1447 Northern Blvd., Manhasset, New York

Dr. ..... Specialty .....
Please print your name

Resident ☐ Intern ☐ Fellow ☐ ☐ Clinical ☐ Research ☐ Special
Please check one

New Hospital .....

New Hospital Street Address .....

City ..... Zone ..... State .....

My chief is Dr. (full name) .....

I expect to complete my training here: ..... month ..... year

Former Hospital Address:

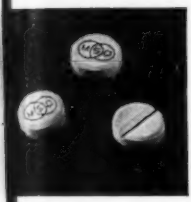
Hospital Name ..... City ..... State .....

n edema or hypertension

ore doctors are prescribing—

more patients are receiving the benefits of—

more clinical evidence exists for—



DIURIL®

CHLOROTHIAZIDE

han for any other diuretic-antihypertensive

URIL is unique. There is no other brand chlorothiazide.

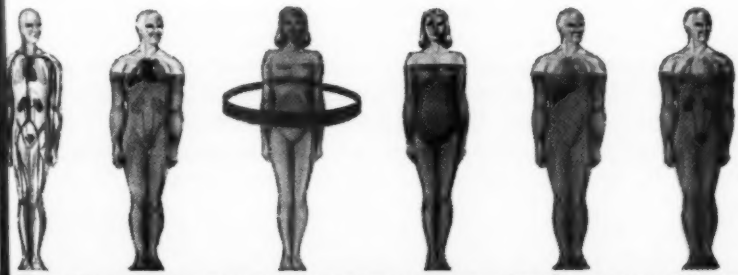
sage: Edema—One or two 500-mg. tablets URIL once or twice a day. Hypertension—e 250-mg. tablet DIURIL or one 500-mg. blet DIURIL two to three times a day.

Supplied: 250-mg. and 500-mg. scored tablets DIURIL chlorothiazide in bottles of 100 and 1000.

DIURIL is a trademark of Merck & Co., INC.

Additional information is available to the physician on request.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.



ERTENSION CONGESTIVE FAILURE PREMENSTRUAL TENSION EDEMA OF PREGNANCY CIRRHOSIS WITH ASCITES RENAL EDEMA

—*Concluded from page 45*

• *Insurance costs vary widely throughout the U.S. The author suggests that leasing is less expensive than owning in some areas—but not all areas.*

Finance Gap

It seems to me that Dr. Cochran, author of "Bridging the Gap Between Residency and Private Practice," is showing more enthusiasm for outpatient clinics than warranted by the facts.

Firstly, what residency in any field doesn't have its share of outpatient clinic work?

Secondly, the "art of medicine" is the same, whether the patient is sitting in a chair or lying in a bed.

Thirdly, the real problem in "bridging the gap" for most practices is primarily a financial one. In outpatient clinics as well as on the ward, any laboratory or special study which might be helpful in establishing precise diagnosis is ordered, the direct cost to the patient usually being small or nil. In private practice, however, every study means five to twenty or more dollars out of the patient's pocket. Unless you treat only affluent patients, this becomes a strong determinant. Hence, there is what appears to me to be the big difference: the problem of giving high quality medical care with a minimum of non-essential laboratory support, trying to spare the patient's pocketbook on the one hand and yet maintaining good medical care on the other.

In a few more years, I suppose President Kennedy's taxpayers will be footing the bill, so it won't make any difference for most. But right now, I believe it is the patient's costs for laboratory studies which makes a big difference between private practice and medicine on the wards or in the clinic.

LAWRENCE PORT, M.D.
N.Y.S. UPSTATE MEDICAL CENTER
SYRACUSE, NEW YORK

Jobs, etc.

Looking back over the past few years of RESIDENT PHYSICIAN I remember a few articles describing various jobs, etc., offered MDs, i.e., "Ship's Physician" and others.

I have decided to take one or two years away from residency training and consider something along this line.

I would appreciate it very much if you would send me any reprints of such articles or be of help otherwise.

Kenneth Philbrook, M.D.
SYRACUSE, NEW YORK

Perrin H. Long, M.D.

Editor's Page

The Problem of Foreign Medical Graduates

I. A BLUNDER

The history of the efforts of "organized medicine" and its subsidiary groups, of which the Educational Council for Foreign Medical Graduates is one, to deal with the problem of foreign medical graduates can hardly be called distinguished, nor has it been an entirely happy one.

From the beginning the approach to the problems and needs of this group has been marked by a spirit of conservatism and local solicitude on the part of the House of Delegates which borders on chauvinism and isolationism, while at the same time hospitals fully accredited have been known to exploit, shamefully, unwitting foreign graduates.

Little attention or real thought has been given to the proposals of those delegations to the House of Delegates of the AMA from those states which have had the greatest experience with the foreign graduates and with visitors and emigrants to our shores in general. This has been especially true as far as the special needs of the State of New York are concerned, in which there are more foreign medical graduates serving as interns and residents than in any other state in the union.

It is to be remembered that the House of Delegates in 1958 approved a recommendation from the Council on Medical Education and Hospitals setting up the ECFMG based on sponsorship from the AMA, AAMC, AHA, and the Federation of State Medical Boards, in expectation that the ECFMG would devise a qualifying examination for foreign medical graduates, and that by July 1, 1960 all foreign medical graduates, citizens or aliens in our land, serving as interns or residents in approved hospitals, would have passed the qualifying examination. The prime motive behind this action was laudable, even though it was expressed badly in the phrase "to protect the health of the hospitalized public." Certainly, when Dr. Paul Hawley wanted to do the same thing, as far as certain American trained physicians were concerned a few short years ago, relative to unnecessary and "ghost" surgery, the House of Delegates rose in "righteous" wrath and did its best to smite him down!

No wonder that almost immediately certain troubles began. First of all, despite its name, the ECFMG never has really concerned itself with the education of the foreign medical graduates in this country. It did not, as far as is known, investigate the indentures under which some foreign physicians worked, nor did it concern itself with the intramural education of foreign graduates in American hospitals, their hospital status, or really anything else except examining them with—for the foreigners involved—exotic types of examinations until it and its supporting organizations, through an error in judgment, brought the State Department down on their collective heads. Furthermore in its activities as a "Council" it carried out its function in a manner which many believe was not consonant with its title; it immediately seemed to constitute and concern itself with being an examining body and, as far as can be made out, without too much thought (or possible knowledge) of foreign medical

education, set up technical types and forms of medical examinations, the likes of which as has been pointed out, most of the foreign graduates had never seen before. What happened is worth remembering. First of all, in the six examinations given up until 1961, but twice have a majority of any category of individuals who took it, "passed" the examination. "Near passes" were recorded for about a fourth of the candidates, and from a fifth to a half of the candidates failed completely in the various examinations which have been given to date. The results of the examination of September 1960, which was taken by almost nine thousand candidates, show that 43.3 percent "passed," that 28.2 percent were "near passes" and that 29.5 percent "failed." *Certainly a type of examination which produces the end results just noted should be considered suspect.*

The areas of origin of the foreign medical graduates are of interest in view of what happened after the results of the September 1960 examination were made public. It was recently stated by the Executive Director of ECFMG that its examinees were derived as follows: Far East—2/6; Latin America—1/6; Near East—1/6; Europe—1/6; Scattered—1/6. Shortly after the results of the September 1960 examination were made public, and it became known that on December 31, 1960, about twenty-five hundred foreign graduates would be dropped by American hospitals, the State Department became involved, because it realized the amount of ill-will and bad publicity which would result from this non-legal directive of the House of Delegates in the uncommitted countries of the world. That it was a serious situation is reflected by the statement made by the Executive Secretary of ECFMG in a letter to your Editor after the latter had asked for data relative to the areas from which those who failed the examination had come and their numbers. This information was refused because, it was inferred, it would be unwise to release it for publication.

Real trouble certainly was brewing. At the meeting of the House of Delegates, AMA, December 1960, the following principle was approved:

"2. In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visas will not be withdrawn before that time. This will also allow non-certified foreign physicians to take the April 1961, Educational Council for Foreign Medical Graduates Examination."

The desires of the State Department are clearly evident in this withdrawal of the House of Delegates from its original stand and another rear-guard action was chalked up for the House.

In December 1960, Governor Rockefeller, having become aware of the situation within the State of New York (hundreds of interns would be lost to hospitals) requested a six months' stay of the action of the House of Delegates. This was completely in line with the recommendations of the Delegates of Massachusetts and New York to the House and which was turned down by the House of Delegates. He won an initial reprieve of sixteen days relative to the provisions outlined in Principle 2, above. But in the final analysis, "organized medicine" as represented by the Council on Medical Education and Hospitals of the AMA, again ignoring the political and social aspects of their action, rejected the Governor's request. It is our opinion that the AMA and other sponsoring organizations will regret their action. However, the Governor did get the approval of the repre-

sentatives of "organized medicine" to establish "intensive training programs" for non-certified foreign graduates at four centers in the State. As reported in the *New York Times* (Jan. 15, 1961): "Mr. Rockefeller, in his announcement, said: 'The cooperation and assistance of the AMA and AHA, together with the establishment of these emergency training programs, will help relieve the immediate crisis in those hospitals in the state faced with the loss of a large percentage of their house staffs.' "

The programs were to complement the "ward clerk" type of programs which the House of Delegates ordered each hospital to set up for the foreign graduates who had failed the September examination.

It is worth while to take a look at these programs and inquire into their educational or training value, bearing in mind that the action of the House of Delegates was based solely on the desire "to protect the health of the hospitalized public." It is indicated in syllabi from three of the four centers in New York State that 48 training exercises were to be set up and divided roughly as follows: Medicine—14 exercises; Surgery—14 exercises; Pediatrics—10 exercises; and Obstetrics and Gynecology—10 exercises. All were didactic in nature. Now obviously, not by the farthest stretch of one's imagination could such a program be called "educational." Similar programs, all didactic, some with fewer, some with more hours, have been set up across the country. Frankly, these programs derogate the philosophy of education and in the long run will bring little credit to their sponsors. Is it training? In the strict sense of the word, it might be called training. Does it have a specific aim in view? The answer is yes! But, make no bones about it, these programs are nothing but cram courses (ten minutes on bacterial pneumonias, eight minutes on tuberculosis), designed for no other purpose than (hopefully) to enable those who enroll in them to pass the examination of ECFMG in April.

Courses such as these which are without educational value will in no way further the announced aim of the House of Delegates "to protect the health of the hospitalized public." And to your Editor, who has been deeply concerned with the advancement of American medical education for more than thirty years, these programs represent the epitome of educational sham and deception. Furthermore, from information received by your Editor, the injunction relative to the "clerkship" status is not being observed in a number of areas. So the comedy moves faster, while at the same time becoming more tragic!

Are there lessons to be learned from our blunders such as this or must we go on being "Ugly Americans?" There is good reason to believe that countries which are more thoughtful or which are politically minded are having a rush of foreign medical graduates applying for graduate education. Your Editor thinks this to be true. He would like to cite from what Professor Arnold S. Toynbee said on the CBS television panel show entitled "Great Challenge" on February 19, 1961. Speaking of a recent visit which he had made to Afghanistan, he said that while both Russia and our country were carrying out great engineering projects, the Russian technicians were invisible—as they lived with and by the people, while the Americans with their special stores for American products, their clannishness, their cars, their separate living areas, etc., stood out like sore thumbs in this uncommitted country. Unfortunately our "create a little America" complex permeates many of our activities, and it would seem to your Editor that the ECFMG and the organizations it represents should hasten to familiarize themselves with the educational backgrounds from which come those who seek educational advancement in this country. Then they should do everything in their power to provide not only here, but also abroad that medical educational environment which will be in the best interests, not only of

hospitalized American patients, but also of our exchange visitors, and of all of us as far as our international relations are concerned. Money to support such a program would be forthcoming. Furthermore, let us remember that had there been a reasonable, and not an arbitrary cut-off date, the dismay, the frustration and the anger caused by the thoughtless cut-off date would not have occurred, and a considerable number of our foreign colleagues would have a much more friendly feeling for us today. The chances are had this been done that the "health of hospitalized patients" would not have been jeopardized. Let's not be "Ugly Americans!" Let's do everything to prepare those who wish to further their medical education aims in our country with the tools to do it. Let's be attractive, not repellent! *This is a task for which a complete and permanent solution can be worked out if a will to do it exists.*

Pierre H. Long,

Foreign MDs Tackle ECFMG Exam

World's Biggest Medical Test—More than 7500 foreign medical graduates took the seven-hour ECFMG exams given early this month in 132 centers in the U. S. and abroad. In New York City, more than 1,350 foreign graduates went through the all-day session in an improvised classroom on the fourth floor of Manhattan's giant coliseum. Results are expected to be available to the examinees during the week of May 17.

When Are *Patients* Neg

Contrary to popular opinion, the doctor-patient relationship in its legal aspect is not a one-sided affair. The patient has obligations, too, as court actions have made clear.

George A. Friedman, M.D., LL.M.

Much is written about the duty of the doctor to the patient, about the doctor's ethical and legal obligations in their relationship. But little mention is made of the corresponding duty of the patient to the physician *and to himself* to use due care in following the directions of the doctor.

Legally, a patient who has failed to exercise reasonable care for his own safety is barred from collecting damages when his conduct was a *substantial contributing factor* to his own injury. Despite a physician's negligence, the patient's own negligence bars legal recovery.

The defense of contributory negligence originated in 1809 in the English case of *Butterfield v. Forrester*.[1] While repairing his house, defendant left a pole projecting across part of the highway. The plaintiff, heading home from a public house at dusk, rode into the pole and was thrown from his horse and injured.

The judge dismissed the case, stating:

"A party is not to cast himself upon an obstruction which has been made by the fault of another, and avail himself of it, if he did not himself use common and ordinary caution to be in the right.

"In cases of persons riding upon what is considered to be the wrong side of the road, that

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would not authorize another to purposely ride up against him. *One person being in fault will not dispense with another's using ordinary care for himself.*"

In a modern American case, plaintiff was injured while working on the heating equipment of a school building. A piece of cement directly above where he was working came loose and struck him in the eye. Five days later, on August 5, he consulted defendant, a physician specializing in the eye, ear, nose and throat. The doctor removed small particles of cement from the eye.

But plaintiff's eye continued to cause him pain and he complained of frontal headaches. On October 28 he visited an optometrist who found his eye and vision normal. On November 22, more than three months after the first visit, he returned to the defendant's office and was found to be suffering from keratitis.

Plaintiff claimed defendant caused the keratitis by failing to remove all the cement particles from his eye during his first visit.

The court held that even assuming some particles had remained in plaintiff's eye, and that they did in fact cause the keratitis, plaintiff could not recover from the physician. Plaintiff was guilty of contributory negligence as a matter of law. Although dissatisfied with his treatment on August 5, he did not consult another physician for nearly three months thereafter.[2]

Certain acts on the part of plaintiff are considered so clearly negligent that the judge instead of submitting the case to the jury will direct a verdict for defendant. The judge in so doing is ruling that plaintiff's act was contributorily negligent as a matter of law.

In one such case plaintiff went

to a physician for a blood test prior to getting married. The doctor advised him to return for a series of injections. On the second visit the physician was intoxicated. Plaintiff objected to treatment while physician was drunk, but was persuaded by the doctor that he was perfectly capable of giving an injection. The injection was negligently administered, to plaintiff's damage. No recovery was allowed.[3]

The plaintiff had failed to exercise the care which prudent persons are accustomed to employ for their own safety. This omission of care on the part of patient, together with defendant's negligence, caused the injury. Because he shared in the negligence plaintiff was barred from recovery.

Determination

Other cases which are not so clear cut are submitted to the jury for a determination of the facts and a decision whether those facts constitute contributory negligence.

Plaintiff's ankle was fractured. Plaintiff refused to take an anesthetic, and no x-ray was available. The physician administered morphine and examined the injury by sight and touch. Later it was discovered that the fibula had been fractured some two or three inches above the joint, and the parts had overlapped.

Defendant pleaded contributory negligence on the grounds that the anesthetic would have so relaxed the swollen muscles that the additional fracture would have been discovered. The jury found for defendant.[4]

Not contributory

Plaintiff became an addict after being treated with morphine to relieve pain after an operation. After plaintiff was discharged from the hospital she complained to her physician of great pain and suffering. Between August and November the physician made no house calls to her, nor treated her organic trouble in any way except to make two or three pelvic examinations. During that period he prescribed morphine by phone to be self-administered for the relief of pain as needed.

In order to get a prescription plaintiff complained of pain when no pain was present.

The court held that plaintiff was not guilty of contributory negligence. She was entitled to rely on the defendant's superior knowledge as to the amount of the drug that could safely be taken over a period of time.[5]

Plaintiff's jaw was fractured when a tooth was removed. Defendant dentist put a bandage around her head to support the jaw. Plaintiff was not told of the fracture, and removed the bandage that evening and did not wear it again. She returned to defendant from time to time to have the cavity caused by the extraction washed out. At no time did defendant advise her to wear the bandage. A month later plaintiff consulted an oral surgeon about the pain in her jaw and discovered the fracture.

The defense of contributory negligence for failing to keep the bandage on the jaw was rejected. Failure to do something patient was not advised to do could hardly be the basis of a claim of contributory negligence.[6]

In a similar case physician told plaintiff there was nothing wrong with him when in fact he was suffering from a fractured vertebra. Plaintiff's failure to stay in bed did not amount to contributory negligence.[7]

The surgeon left two gauze pads in plaintiff's abdomen. There was a prolonged delay in healing after the operation was performed. Some five weeks later during a hernia operation the gauze pads were discovered; the wound healed in a few days.

The surgeon charged that plaintiff was contributorily negligent in not disclosing her suffering and symptoms to him, but the jury found for the plaintiff.[8]

Disobedience

If a patient neglects and refuses to obey a physician's instructions, and if his failure to follow such instructions directly contributes to his injury, he will be barred from recovery even though the physician is also negligent in treating the case.

Plaintiff was hospitalized following an automobile accident and his broken leg set with a Thomas splint and Buck's extension. During the night patient pushed the weights down until they were useless. They were readjusted, but again patient pushed the splint down his leg, destroying the use of the weights. After eight days of uncooperative behavior defendant performed an "open operation." Plaintiff attempted to remove the cast, removed the dressing from the opening in the cast, and abused the leg.

The court held that the mental and physical pain sued for were a result of patient's behavior, albeit physician's negligence may have been a contributing factor. No recovery was allowed.[9]

Similarly a patient cannot recover when he refuses a physician's suggested treatment or fails to return for treatment.

But there is no contributory negligence when a patient is dissatisfied with treatment and consults another physician.

Aggravation

There are cases in which a physician's negligence caused injuries to the patient. After having sustained these injuries the patient by his own negligence aggravated the damage. Patient's negligence is not a defense which will bar an action against physician, but it will affect the amount of damages recoverable by patient.

Damages will be assessed to the extent patient suffered injury at the hands of the physician. His own aggravation of those damages will not be recoverable from the physician.

A physician prematurely took the splints off patient's broken arm. (This constitutes negligence.) He advised patient to go to the hospital and have the arm rebroken and reset. Patient refused. If the jury determined that in the exercise of ordinary care patient should have followed this advice, then recovery against physician would be prevented only to the extent that damage were thereby enhanced or increased.[10]

Assumption of risk

Assumption of risk is another defense to a malpractice action somewhat similar to that of contributory negligence. It means that the plaintiff is aware of a known risk, and takes his chances of injury from it. He relieves defendant from responsibility therefrom.

A doctor may suggest a procedure which is new or known to be risky. If the patient is made aware of the risk, and agrees to the procedure, he has no recourse when damaged.

In the case of x-ray a patient assumes the risk of burn from a proper exposure to x-ray. But he does not assume the risk of physician's negligence in the use of the x-ray.

Third persons

The contributory negligence of a third person in charge of the patient can bar recovery. Thus a 6-year-old child suing for malpractice would be charged with the negligence of his parents in carrying out the doctor's orders.[11]

A defendant physician sent a substitute physician to care for patient. Patient's husband was

drunk, and threatened the substitute with a pistol, alarming and exciting him to such an extent that he was unable to use ordinary care in treating patient. Patient was charged with her husband's contributory negligence, and barred from recovery.[12]

Minors

Infants and young children (the age limit seems to vary between 12-14) are not subject to any technical rule of contributory negligence. However, a child may act in a way which will change the condition provided by the treatment of the physician, thus breaking the casual connection between the treatment and the injury complained of. So if a child jumps and plays with a bandage on its arm, displacing a fractured arm, the doctor will not be charged with the displacement.

Reliance on advice

Plaintiff was hit by a car, dragged several feet and knocked unconscious. He was treated by the defendant at his hospital. When he was discharged from the hospital, a month later, his left arm and shoulder were badly swollen and he carried his arm in a sling. Plaintiff told defendant of the aches and pains in his arm and shoulder, and defendant replied, "Well, it will be a long time, but it will be all right."

Three months after his discharge the patient again complained of constant pain and the defendant gave the same reply. Seven months later, when plaintiff experienced a sudden shoulder pain another physician discovered and treated a dislocated shoulder.

Defendant claimed plaintiff was negligent in not seeking medical assistance elsewhere during the seven month period. The court held plaintiff was justified in relying on defendant's advice that the injury would take a long time to heal.

"There is no claim or evidence that plaintiff had any knowledge as to the proper mode of treatment of injuries of this nature. He was engaged in the ice business and was not a physician or surgeon.[13]

The court quoted with approval the language in a 1901 case:

"It is not a part of the duties of a patient to distrust his physician, or to set his judgment against that of the expert whom he has employed to treat him, or to appeal to other physicians to ascertain if the physician is performing his duty properly. The very relation assumes trust and

confidence on the part of the patient in the capacity and skill of the physician: and it would indeed require an unusual state of facts to render a person who is possessed of no medical skill guilty of contributory negligence because he accepts the word of his physician and trusts in the efficacy of the treatment prescribed by him."[14]

Comparative negligence

The doctrine of contributory negligence places a great hardship on the plaintiff. For he must bear the entire burden of a loss for which two people were responsible.

Dissatisfaction with the defense of contributory negligence makes courts less inclined to rule that an act amounts to contributory negligence as a matter of law, and juries more inclined to find that there has been no negligence.

Civil law courts and admiralty courts apportion the damages, and many labor acts provide that contributory negligence of an injured workman shall not bar his recovery, but his damages shall be reduced in proportion to his negligence.

The United States is one of the last strongholds of contributory negligence. But while the move is growing in this country to divide the damages, it has yet to reach malpractice cases.

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7. Wilson v. Corbin, 41 N.W. 2d 702 (Iowa, 1950).
8. Reynolds v. Smith, 127 N.W. 192 (Iowa, 1910).
9. Stacy v. Williams, 69 S.W. 2d 697 (Ky., 1934).
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11. Sanderson v. Holland, 39 Mo. App. 233 (1889).
12. Lee v. Moore, 162 S.W. 437 (Tex., 1914), 211 S.L.W. 214.
13. Halverson v. Zimmerman, 232 N.W. 754, 759, (N. D., 1930).
14. Schoonover v. Holden, 87 N.W. 737 (Iowa).

48 additional awards made in Resident Physician's Mediquiz Contest

HONOR AWARDS

As a final chapter in the Resident Physician Mediquiz Contest, 48 house officers have been awarded honorable mention prizes.

So close was the contest competition that a special Honor Award class was added by the publisher to the original prize list "In order to give proper recognition to those who missed a Contest prize by the narrowest of margins."

A permanent memento with an inscribed plaque has been sent to each Honor Award winner, none of whom scored less than 93% in the Contest. Our congratulations to these winning house staffers.

Honor Award Winners

CALIFORNIA	RAZAVI, MOHAMAD, Highland-Alameda County, Oakland ROSEN, SAUL W., U. of C. Medical Center, San Francisco SWAFFORD, GERALD R., Ft. Miley VA Hospital, San Francisco
COLORADO	BUCKNER, MICHAEL S., Colorado General, Denver WASSERMIL, MENDEL, General Rose Memorial, Denver
DISTRICT OF COLUMBIA	ORJUELA, REYNALDO, Washington Hospital Center, Washington
FLORIDA	BECKER, DAVID J., Coral Gables VA Hospital FYVOLENT, JOEL D., Coral Gables VA Hospital
ILLINOIS	FRABLE, MARY A., Michael Reese, Chicago FRABLE, WILLIAM J., Passavant Memorial, Chicago
IOWA	LARSON, LELAND J., Iowa Methodist, Des Moines
LOUISIANA	DUGAS, JOSEPH E., JR., VA Hospital, New Orleans
MARYLAND	COHEN, SIDNEY J., Mt. Sinai Hospital, Baltimore LINN, BERNARD S., VA Hospital, Perry Point
MASSACHUSETTS	CURRAN, WILLIAM S., New England Center, Boston FRIEDMAN, ELI A., Peter Bent Brigham, Boston GUREWICH, VICTOR, West Roxbury VA Hospital
MINNESOTA	BLODGETT, RANDOLPH C., JR., Mayo Clinic, Rochester JOHNSON, ARTHUR G., St. Joseph's Hospital, St. Paul MORRISON, MURRAY G., Mayo Clinic
MISSOURI	BOREN, CHARLES W., St. Luke's Hospital, St. Louis
NEW HAMPSHIRE	BONG, WIE L., Mary Hitchcock Memorial, Hanover
NEW JERSEY	CASTLEMAN, JAMES F., Fitkin Memorial, Neptune GOMES, JOSE P., Overlook Hospital, Summit JURKOIC, JOSEPH A., Fitkin Memorial, Neptune
NEW YORK	ANZIL, ARCHINTO P., Kings County Center, Brooklyn BAUMAL, ALLEN, Mount Sinai, New York City BUHLMEYER, MARIE T., Mount Sinai

	FARPOUR, ALI, Metropolitan Hospital, New York City
	FARRELL, WALTER J., U.S. Public Health Hospital, Staten Island
	KOHASHI, NAOKO, Hospital for Joint Diseases, New York City
	MOHAN, RADHA, Bellevue, New York City
	ORTEGA, VIOLETA V., Meyer Memorial, Buffalo
OHIO	OTTE, RAY C., University Hospital, Cleveland
	RODA, JAMES J., University Hospital
	SHAW, RUSSELL F., Children's Hospital, Columbus
	SPITZER, SIMON, The Jewish Hospital, Cincinnati
PENNSYLVANIA	BARRETT, STEPHEN J., Temple University Hospital, Philadelphia
	KRATZ, CHRISTA C., Jefferson Medical College Hospital, Philadelphia
	SACKNER, MARVIN A., Philadelphia General Hospital, Philadelphia
	STRAUGHEN, WILLIAM J., Allegheny General, Pittsburgh
	WELLS, CHARLES L., Presbyterian Hospital, Pittsburgh
TENNESSEE	HERRERA, ABELARDO C., West Tennessee T.B. Hospital, Memphis
TEXAS	BENDEL, WILLIAM L., JR., Baylor University Medical Center, Dallas
	ISHAK, KAMAL G., Baylor University Medical Center
	JONES, ROBERT F., Parkland Memorial Hospital, Dallas
	VINSON, WILLIAM M., Lackland Air Force Hospital, San Antonio
VIRGINIA	SAND, RICHARD E., U.S. Naval Hospital, Portsmouth

IN RESIDENT PHYSICIAN NEXT MONTH—

- Answers to the entire series of Mediquiz Contest questions (August through December).
- Answers to the special series of 50 tie-breaking questions.
- Journal references for all of the questions and answers

Foreign Medical Graduates and the American Qua

A foreign resident points to the world-wide effects of foreign MDs' training in the U.S., expresses concern for certain aspects of the ECFMG program

Jose Aq. Aquino, M.D.

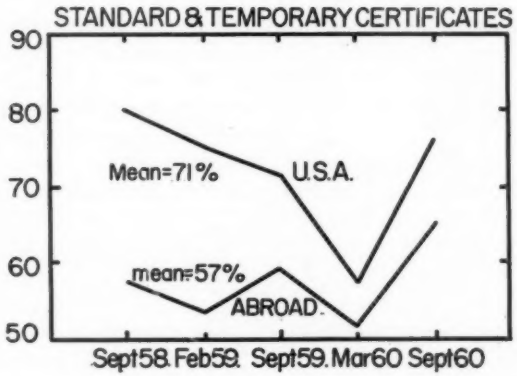
In a recent article written by Bearse which appeared in the *New England Journal of Medicine,* a table was included showing the results of the American Qualification Examinations as supplied by Doctor Dean Smiley of the Educational Council for Foreign Medical Graduates. As will be remembered, the Council was established in October 1957, under the sponsorship of the American Medical Association, American Hospital Association, Association of American Medical Colleges and the Federation of State Medical Boards. The main purpose of the Council was to protect the hospitals and the public from residents and interns who are inadequately trained. The Council under the leadership of Doctor Dean Smiley has done a very commendable job.

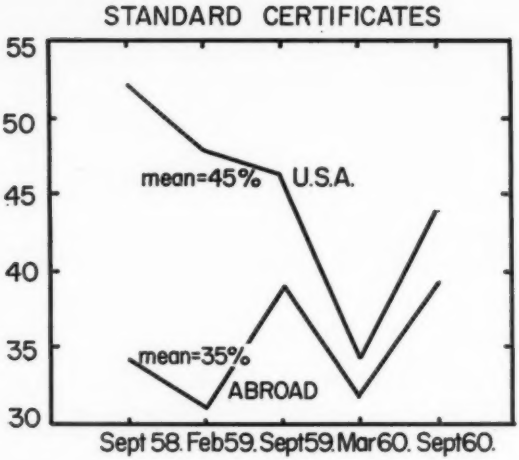
In this presentation will be

Qualification Examination

graphs which are modification of the table showing the results of the American Qualification Examinations both in the United States and abroad. Graph I illustrates the fact that 80 percent of those examined in the United States in September 1958, attained scores of 70% or more. In contrast to this, only 58 percent of those who took the examinations abroad were able to score as high as 70%. This is indeed a significant difference, although many attribute this to the language barrier. Since the first exam, however, there has been a continuous downward trend. In the recent (March 16, 1960) exam, only 56 percent

GRAPH I





GRAPH II

received grades of 70% and higher in the United States. In two out of the four exams (through March 1960) the 56 percent figure was surpassed by those abroad, indicating that the latter group scored better than those who took the examinations in the United States last March 16, 1960.

Difference

Graph II, representing those awarded the "standard" certificate (75% grade required), also shows a significant difference in the results in the first exams. In the last examinations, there were only 34 percent of those who took the examinations in the United States who made a mark of 75% or higher. This had also been surpassed by the group abroad.

Upon viewing the graphs, a few questions arise. Is the training now being given in most hospitals really adequate? There have been many articles pertaining to the foreign medical graduate. Most have emphasized "inadequate training." This is not only confined to the medical profession but has reached the lay press where it has been treated dramatically and sensationally, with the implication that the foreign medical graduate is a second rate physician.

Although some of the foreign medical graduates have enjoyed

excellent opportunities during their training, many have been disappointed. Foremost among the reasons for disappointment is the failure of the foreign medical graduate to obtain advanced training in the United States. He often finds that the educational programs in the hospitals are thin and in some cases, almost nonexistent. He also finds that his real assignment is the performance of basic service. He is asked to take a history and perform a physical examination which is included in the patient's chart only because it is required for the accreditation of the hospital. The attending physician does not look at it, nor does he offer the "bedside teaching" that is so often spoken of. The foreign medical graduate considers much of his experience a waste of his time. The attendings are often too busy and do not have time to teach.

Like the professional staff, the administrative staff appears mainly interested in the foreign medical graduates' basic service function. This is particularly true in the non-teaching hospitals; unfortunately these hospitals are the majority of U. S. hospitals. On the other hand, in the teaching medical centers, the foreign medical graduate becomes "a part of the team." Yet, commonly he is looking on but rarely participating in a responsible role—a role often limited to the favored few.

Evaluate

Another question: Is the AMQ examination really the best way to evaluate the foreign medical graduate's ability to take care of the patient? As one delegate to the American Medical Association meeting last June put it, "In my opinion, some of the foreigners who have failed the ECFMG examinations are better than some who have passed. Why, under the Council's present regulations, Sigmund Freud would not be allowed to practice psychoanalysis here." Of course that

ABOUT THE AUTHOR After an MD and internship in the Philippine Islands, the author came to the U.S. under the Exchange Visitors Program for an internship at Holy Family Hospital, Teaneck, N. J., three years of resident training at Martland Medical Center, Newark, N. J., and an added year in oncology at the American Oncologic Hospital in Philadelphia. He is at present in the Department of Therapeutic Radiology, Royal Victoria Hospital, Montreal.

is his opinion, which may or may not be shared by many others.

Actually, many, if not all of those taking the AMQ examinations in the United States have already had a few years of "advanced training." Many are serving residencies in other specialties than those of their advanced training. Why then would their knowledge be equal or less than their counterparts abroad who have not had any of the "advance training?" This is hard to explain and even harder to accept.

The foreign medical graduates form a very important group. They not only play a vital role in the proper functioning of the hospitals or completion of the research projects but are also a challenge. (That is, if one accepts the challenge.) Their backgrounds and training are so varied. Those in authority should accept and not shirk their responsibilities to these foreign medical graduates and the world. They are not only a big help in the care of the patients and in research, but are invaluable emissaries of good will to all nations. The medical profession all over the world looks to the United States not only for leadership but also for assistance. As stated in an editorial of the *Journal of American Medical Association,* "hospital administrators, boards of trustees and professional staffs should recognize their responsibility and challenge to offer the foreign medical graduate whom they accept an educational experience worthy of American Medicine and one that will serve him well when he returns to his own country."

It may then be worthwhile to make the primary purpose of the Educational Council for Foreign Medical Graduates not only "to protect the hospitals and the public from residents and interns who are inadequately trained" but also to protect the foreign medical graduate, who looks to the United States for leadership

EDITOR'S NOTE: *In a November issue (1960) of the* WALL STREET JOURNAL, *it was stated that in the examination held in this country last September, 28 per cent of those taking the ECFMG examination failed, 28 percent will have to take another examination, and but 44 percent "passed." 8713 foreign graduates took the examination here and abroad. The percentage who "passed" represents a slight improvement over the last examination.*

and assistance, from those hospitals not adequately equipped to give him an educational experience worthy of American Medicine.

The Council should furnish the foreign medical graduate the actual and accurate picture of the educational opportunities which are available to him in the different hospitals and teaching centers, so that he will not lose confidence in those he trusts.

The Council should continue to screen the foreign medical graduates so that only those found to be qualified either through the AMQ examinations (or other means to be used to determine their ability to care for the patient) be allowed to assume the very responsible position of interns and residents in hospitals in this country.

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". . . Well, young man, are you a doctor, an intern or a foreign intern?"

I Passed the ECFMG Exam, *But...*

Now in a U.S. hospital, under the Exchange Visitors Program, a physician from Thailand tells of his mixed reactions to our handling of foreign medical graduates, and offers some suggestions for changing the present situation.

"Where do you come from?" an instructor in Economics of a college asked me at a party held by an acquaintance of mine.

"From Thailand, Sir!"

"Oh! It is an underdeveloped country, isn't it?" he added without thinking.

"Yes, Sir! You are right." I was flushed with a little embarrassment by the unexpected question. But he switched to another topic of conversation and everything was going fine at the party. I was warmly welcomed by the American host.

Yes Sir! I came from an "underdeveloped" country where we had had only one 60-year-old, modern medical school although two more were established after the World War II. Most of our professors and instructors were graduates or postgraduates from Europe (including Great Britain). Some of them of course were from U.S.A. After graduation and completing my internship I came to Europe according to the suggestion of a professor who was once again, postwar, in both U.S. and Europe.

"You will learn methods and techniques in Europe, which can be applied better in our country

and later on you may go to America to learn something more which you would hardly apply to our country because we are not millionaires who can afford such excellent laboratory and research equipment." I came to the U.S. though in 1958.

ECFMG Exam

I heard of the ECFMG but the rules were not yet in effect. I did not pay attention to it nor dream to take the test. But after failing to get a residency (the hospital I first landed in has no residency training program) with the answer to my application, "We prefer ECFMG - certified doctors," I began to realize that it was the time that I had to pay attention and dream to take the AMQE of the ECFMG, otherwise I must pack my pans and pants and go home. At home the test is an essay-type test. If you know the answer, write all you know and as much as you can; of course, in our mother-tongue language.

If you do not know the answer, write as if you knew it, also as much as you can to confuse the examiner and make him think that you knew it. It would not make much difference if you described the intermittent claudication that it is an insufficiency of the arterial circulation, regardless either absolute or relative, because the examiner has more to read and find out whether you have some idea about Berger's disease or not.

Here you have multiple choice type questions. I tried to get acquainted with this type of question from many sources as much as I could, e.g., from Mediquiz® of RESIDENT PHYSICIAN. Because we have almost all of the textbooks in English, of both American and British authors, at home, I did not find any difficulty in reviewing all these standard American textbooks. But I would like to remark at this point that for those who get in touch with the English language for the first time it might be pretty difficult—but many of them did fine and passed the test.

Quiz

After my credentials were approved and $35 was paid, I went to take the examination of the ECFMG which theoretically would qualify me to be equivalent to an American graduate—although practically we might still be a "foreign body" or even "parasite" from a standpoint of view of some Americans and some State Boards.

This type of multiple choice

questions did help me a lot in picking out the correct answer when I had only slight idea of that question, because the correct answer would make some suggestion or clue to me, although sometimes I was faced with a "crazy" question like "Which do you like best, roast turkey or brandy?" on which I had to toss a coin in order to cross only one answer (because I like both roast turkey and brandy).

Certificate

Finally, after waiting with palpitation for 6 weeks, there came a letter from Dr. Smiley, "We are pleased . . . Congratulations!" Bravo! I am recognized as a physician in this country again, though I have had my title of M.D. and license to practice medicine in my homeland for some time.

The purpose of every hospital in the world is the welfare of its patients. After World War II there has been increasing demand of house staff in American hospitals to take care of their patients. What did you do to meet that demand because of less supply of American graduates? You looked for foreign graduates who at least had fulfilled their duty and were eager to learn from you.

In this world there are always both good and bad people and so are the foreign graduates and you Americans. Among the foreign graduates there surely are some poorly trained ones who come to this country to learn better Medicine. The U.S. Department of State realized the fact that in face of this cold war the U.S. should help underdeveloped countries more, and developed a program, Exchange Visitor Program, in order to help foreign graduates from both underdeveloped countries and "well-developed" countries of old world to learn "better" Medicine and American Democracy and "to wash the brains" of these foreign graduates to become "Ambassadors" to their homelands, with the hope that they might be able to talk their people out of the idea of getting rid of American Bases in their countries, if any such idea occurs.

I think, the foreign graduates who fail the ECFMG exam should be helped and encouraged to come to the U.S. to learn "better" Medicine more than the ones who pass it. You might argue, "What do you think about the welfare of our patients treated by these poorly trained doctors?" My counter - question would be, "How do you, American interns fresh from Medical

School, treat your patients?" You treat your patients under supervision of residents and attending staff doctors, don't you? And so do we. The welfare of your patients is the primary responsibility of the attending physician or the man on service of that month. You are responsible to teach American interns as well as foreign interns.

Language

It is only the language barrier that plays an important role. How to overcome that barrier is to learn the language. You can have the foreign graduates who want to come here have a test for English knowledge at the American Embassy, Consulates or the USIA (United States Information Agency).

Besides, you should accept only the graduates who meet the qualifications required by the ECFMG, i.e., "evidence that he has completed satisfactorily 18 or more years of formal education, at least four of them in a recognized school of medicine," and by no means you should accept a graduate who came from secondary school directly to medical school, as someone claimed that it be the case in some countries. (Which countries?)

As to the 360 questions I would like to make a compromise that the passing score of 75% should be reduced to 70% and the score for the temporary certificate should be 65 to 69%.

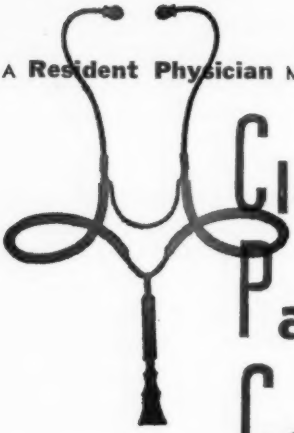
Teach

The above mentioned suggestions might work out well for both sides, you and us. You would get enough labor you need from foreign graduates and we would learn better Medicine we want to become your good-will ambassador back in our countries. The only thing is that you should take more pains to teach us, at the beginning, to overcome the language barrier and to understand the American methods of treatment which might be slightly different from what we learned in our medical schools.

If you want to keep your bases and good-will in these non-communist countries, you have to give them something in return on the basis of "give and take," not only "take and take."

At this point I should like to emphasize that we, people of an underdeveloped country, are still grateful to your help of American people but I only want to remind you that you might be overlooking this little but perhaps important tactic in fighting the present cold war.

A **Resident Physician** MONTHLY FEATURE



Clinical Pathological Conference

Meadowbrook Hospital, Hempstead, L. I., New York

A seventy-year-old, single, white male was admitted for the second time to Meadowbrook complaining of back pain.

For about six years, the patient had "generalized rheumatism," mainly confined to the hips and back. This pain had progressively increased in severity, and had become particularly severe during the few days prior to admission. Shortness of breath with moderate orthopnea had been present for about six months. There was ankle edema of one week's duration. The patient admitted to some slowing of the urinary stream. However, there was no dysuria, frequency or nocturia.

The first Meadowbrook Hospital admission had been for a tendon sheath infection of the left fifth finger. There had been an appendectomy performed many years previously. As a young man he consumed ten whiskeys and smoked three packs of cigarettes daily. The family history was noncontributory.

Physical examination revealed an emaciated, elderly, white male

DISCUSSANT:
H. P. Torres, M.D., resident in urology

PATHOLOGIST:
G. N. Pupino, M.D., resident in pathology

RADIOLOGIST:
S. M. Green, M.D., resident in radiology

PARTICIPANTS:
J. G. Egner, M.D., chief resident in urology
E. J. Bien, M.D., director, biochemical and isotope laboratories

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with a pervasive odor of alcohol. Temperature, blood pressure and pulse were normal. Head and neck showed nothing unusual. Examination of the respiratory system showed an increased chest diameter with diminished breath sounds.

The PMI was in the sixth intercostal space, 2 cm outside the mid-clavicular line; a regular sinus rhythm with occasional PVC's was noted, together with a Grade 2-3 systolic apical murmur. The liver edge was questionably palpable 2 cm below the right costal margin, and an old postoperative scar was present in the right lower quadrant. Rectal examination revealed an apparently normal prostate, and a 1+ benzidine stool. The genitalia were normal. The back was not tender. The extremities showed 1-2+ pitting ankle edema. Neurological examination was normal.

Laboratory

The urine contained many bacteria, otherwise, the examination was normal. Bence Jones protein was absent from the urine. The hemoglobin on admission was 7 grams, and later fell to 5.2 grams. The white blood count was 7,200 with 55 neutrophiles, 44 lymphocytes, 1 basophile. The platelet count was 164,300. Coagulation time, bleeding time, and prothrombin time were normal.

Blood urea values varied between 27 mg.% and 36 mg.%. Blood sugar was 129 mg.%. Blood proteins were normal. Alkaline phosphatase, on admission, was 170 King Armstrong units; repeat two days later was 200 King Armstrong units. Acid phosphatase was 17 King Armstrong units. Sodium, chloride and potassium levels were normal. Serology was negative. Cephalin flocculation was negative. A bone

marrow examination revealed a clump of atypical cells suspicious for malignancy, as well as erythrocytic hyperplasia. EKG on admission showed auricular fibrillation and right bundle branch block.

Course

Because of the high phosphatase values, radiological data and bone marrow reports, the patient was transferred to the GU Service as a possible candidate for orchidectomy with the probable diagnosis of carcinoma of the prostate. On the transfer note, the possibility of a firm area in the left lobe of the prostate was mentioned. On the eleventh hospital day, the patient was scheduled for orchidectomy, but during anesthesia induction, he vomited and aspirated.

He was immediately bronchoscoped, and a Levine tube was passed, which returned bloody fluid. The operation was cancelled. The patient continued to pass a considerable amount of blood via the Levine tube, and he had several episodes of hematemesis. A surgical consultant advised conservative therapy with barium studies later. A Sengstaken tube was passed with no relief of bleeding. The patient's condition remained unimproved and, despite multiple transfusions Synkavite, Premarin, and digitalis he expired on the twenty-fifth hospital day.

X-ray

DR. GREEN: The admission chest film demonstrates pulmonary emphysema and left ventricular hypertrophy. There are also sclerotic changes of the ribs suggesting metastatic disease. Examination of the dorsal and lumbar spine, four days later, demonstrates extensive alteration of the trabecular pattern in the lumbosacral spine, pelvis and both femora. There is evidence of rarification and sclerosis with the sclerosis of the above mentioned bones much more prominent. An intravenous pyelogram, 9 days after admission, demonstrates delayed clearance of the dye through the left upper urinary tract with what appears to be minimal calicectasia.

There is no evidence of neoplastic process. A repeat examination of the chest, taken on the twenty-fourth hospital day, demonstrates marked accentuation of the parenchymal markings throughout both lung fields with confluent areas of patchy density. These findings are suggestive of a diffuse aspiration pneumonitis or possibly pulmonary edema.

Conclusion: Changes in the bones strongly suggestive of metastatic disease, the prostate gland seeming the most likely site for the primary.

Differential diagnosis

DR. TORRES: The outstanding problems to be resolved from the standpoint of diagnosis in this case, are the following:

- Presence of generalized rheumatic-like pain
- Sudden onset of hematemesis
- Presence of cardiorespiratory signs and symptoms
- Elevation of the alkaline and acid phosphatase
- Presence of severe anemia.
- The basic pathology underlying the radiological bony changes and bone marrow findings

First of all, the differential diagnosis in this case could be multiple and complex. However, as I assess the facts of the clinical history, I shall center my discussion on the following clinical entities, and establish my diagnosis accordingly.

Could this patient have had carcinoma of the prostate with widespread metastases? Objectively, without considering the other diseases this patient might have had, I would say this is the most likely diagnosis. The basis for this assumption is the following: Rectal examination revealed a suspicious firm area in the left lobe of the prostate, elevation of the acid and alkaline phosphatase, radiographical evidence of bony metastatic disease, the presence of a clump of atypical cells suspicious of malignancy in the bone marrow smear, chronic pain in the back and hips and, last but not least, the appearance of severe anemia.

Questions

However, several questions are presented. Should I depend entirely on these findings to establish my diagnosis and subject this patient to surgery for a presumed carcinoma of the prostate? Certainly not. In this regard, I wish to clarify certain points which, in my opinion, could prove or disprove, the contemplated diagnosis. The rectal evaluation of the prostate in this case is open to question. There was not an adequate subsequent workup, and a very meager attempt was made to rule out other clinical entities that this patient possibly could have had.

I would prefer to have had serial acid and alkaline phosphatase determinations. Since only one acid phosphatase was done,

I am unable to accept without reservations, the validity of the laboratory report. The possibility of a laboratory error cannot be completely ignored. The specificity of the particular procedure used in the determination of the enzyme could account for a possible erroneous result. It should be remembered that in the blood plasma or serum, two types of acid phosphatase exist. One type is assumed to originate mainly in the liver and spleen, and the other type is of prostatic origin. The chief, if not the only, clinical significance of the serum acid phosphatase of prostatic origin lies in relation to the diagnosis of metastasizing prostatic carcinoma.

In a large proportion of prostatic cancers, the malignant cells retain the capacity to form large amounts of this enzyme, even after metastasizing to other tissues. Inasmuch as no other tissue is capable of forming a significantly large amount of this enzyme to raise its concentration in the blood plasma or serum to a high level, such increases may be regarded as presumptive and, at times, conclusive evidence of the presence of prostatic cells in the lymphatics. It should be understood that in some cases of highly anaplastic prostatic carcinoma, especially in older people, the serum acid phosphatase may be normal.

Enzyme

The elevation also of the alkaline phosphatase is significant. This enzyme mainly originates in the bones where it is formed in large amounts by the functioning osteoblasts. In addition, the alkaline phosphatase also increases in hepatic and biliary tract disease. In the case under consideration, therefore, it is fair to assume that the increase in this substance reflects more or less the physiologic status of the hepatobiliary tract and the skeletal systems. Bearing in mind the presence of radiographic evidence of destructive lesions in the patient's bones, we could assume that the increase of the alkaline phosphatase was a reflection of the activity of the bone matrix.

The absence of evident active or severe hepatobiliary tract disease, the lack of laboratory data regarding calcium and phosphorous levels, the inability to palpate masses in the neck and upper substernal area, coupled with the absence of a recurring renal stone formation and of typical bony changes suggestive of hyperparathyroidism make me think strongly that these disease entities

were not responsible for the elevated alkaline phosphatase in the blood.

Could the bony changes represent the picture of Paget's disease? The absence of facial changes secondary to the cranial vault enlargement and other significant clinical laboratory data rule out this diagnosis.

Multiple myeloma is worthy of consideration. However, the absence of eosinophilia, myeloma cells in the blood and bone marrow smears, hyperproteinemia with increase in the globulin fraction, make this diagnosis remote. Significant in this patient was the absence of Bence Jones protein. The substance is present in the urine of about 40-50% of the patients with multiple myeloma.

I wish that this patient had had the benefit of a prostatic biopsy, cystoscopy or cystourethrography. The latter procedure would have been helpful in defining the cause of the minimal caliectasia in the left kidney.

Was it due to prostatic cancer invading the urinary bladder, or a primary malignancy process arising in the bladder? Could it have been due to a left ureterovesical stenosis, a stone in the left ureter or an extrinsic mass? If a biopsy had been done, it is highly probable that prostatic carcinoma, if present, could have been found.

Bone changes

How about the radiographic bony changes that are apparent? The lesions in the bones were described as osteolytic. In the majority of cases of prostatic carcinoma, the bony metastases are osteoblastic. Osteolytic lesions occasionally occur. In fact, it is not unusual to find lesions which appear as both osteolytic and osteoblastic.

Evidence which does support the diagnosis of prostatic carcinoma is the presence of atypical cells in the bone marrow smear. It is not unusual to find extensive bone marrow metastases in the prostatic cancer and this in turn could partly account for the presence of anemia. The onset of sudden hematemesis is difficult to explain on the basis of prostatic cancer. However, in the last few years some reports have mentioned the sudden onset of urinary and rectal bleeding in association with carcinoma of the prostate.

Could the hematemesis be explained on the basis of a fibrinolytic process in the blood as a result of hemostatic imbalance between the plasmin and antiplasmin components in the circula-

tory enzyme system? This hypothesis, in my opinion, is highly unlikely until further evidence accumulates to establish its existence beyond a shadow of a doubt. One of the outstanding complaints expressed by this patient was increasingly severe pain in the back and hips. This symptom is very common in prostatic cancer with widespread bony metastases. However, it cannot be relied upon too strongly in view of the fact that there are other diseases which may present similarly.

Ulcer

Could this patient have had a bleeding or perforating peptic ulcer? It does not seem likely. However, because of the high incidence of massive gastrointestinal hemorrhage in this condition, I am obliged to consider it in the differential diagnosis. The following facts would appear to rule out this possibility: Peptic ulcer is more common in the younger age groups; this patient's symptomatology was not consistent with a peptic ulcer; there was not sufficient workup to justify the existence of a relatively asymptomatic gastric or duodenal ulcer; a perforated peptic ulcer can hardly be considered in the absence of abdominal findings by palpation and radiographic evidence of free air under the diaphragm.

Could this patient have had carcinoma of the stomach? This is a more likely possibility, and would be consistent with the patient's age. Not infrequently gastric carcinoma may be asymptomatic for a long time and unless there is bleeding or symptoms and signs of obstruction, it develops insidiously. Occult blood (1+) in the stool was reported on one occasion. This patient was markedly cachectic. I would be happy if serial stool examinations for occult blood had been done. For all we know this patient might have been bleeding insidiously into the gastrointestinal tract.

The presence of progressive and severe anemia could have been secondary to gastrointestinal bleeding, infiltration of the bone marrow by metastases, and to poor assimilation and absorption of essential food elements. The presence of osteolytic lesions in the bone is certainly suggestive of gastric carcinoma. In about three percent of the cases of gastric cancer, massive hematemesis occurs. Again, I am not too happy about the omission of many valuable laboratory studies which would have aided in the

diagnosis of gastric carcinoma. A gastric analysis, GI Series, and barium enema would have been of great value. The rectal examination contributed little information to the overall evaluation of this patient. Following the argument I advanced in the consideration of prostatic cancer, the presence of pain in the back and hips does not impress me particularly.

Other causes

A PHYSICIAN: Doctor, does one ever see acid and alkaline phosphatase increased in carcinoma of the stomach?

DR. TORRES: Strictly speaking, the answer is yes. The acid phosphatase of the blood is produced by a variety of human tissues. For this reason, its increased level in the blood and its biological behavior should be carefully studied and interpreted before a conclusion is drawn. It is common knowledge that in clinical practice an increase of this enzyme in the blood suggests prostatic carcinoma. However, some cases have been reported which indicated an increase in the acid phosphatase in the blood in diseases other than prostatic carcinoma.

Howard Simon and Kaare Nygaard reported in 1959 in the JAMA, a case of undifferentiated mucin-producing carcinoma of the stomach having a persistent elevation of the acid phosphatase. No biopsy of the prostate gland was done but rectal examination revealed the prostate to be benign in nature. On an empiric basis, the patient was given hormonal therapy and orchiectomy was done. Follow-up determinations of the acid phosphatase revealed that there was no decrease in the blood level but rather its high value persisted.

Another instance of increased acid phosphatase in the blood was reported by Lester Tuchman, Gilbert Goldstein and Martin Clyman in the *American J. of Medicine,* 1959. They claimed that the finding of an elevated serum acid phosphatase which is not inhibited by L-tartrate, formaldehyde or copper should suggest the possibility of inapparent Gaucher's disease or serve to support the diagnosis in suspected cases. Eight cases of Gaucher's disease were investigated and all of them showed elevation of the acid phosphatase in the blood. The authors also claimed to have followed a sixty-year-old man with gout over a period of one year and they were not able to explain the repeated elevated values of the enzyme.

Various diseases

Helen Woodard reported a large number of patients in the *American J. of Medicine,* 1959, with elevated acid phosphatase in the serum, including normal men and women and patients of various diseases unrelated to the prostate. Of the abnormal cases, about 10% had osteogenic sarcoma, and 15% had Paget's disease of bone. The remainder were divided equally between patients with metastatic disease of the bone, various types of benign or malignant primary bone tumors other than osteogenic sarcoma, and various diseases unrelated to bone but often involving the liver.

In addition to the above noted cases, I am reporting two cases wherein the increase of the acid phosphatase could not be related to prostatic carcinoma. One is a case of carcinoma of the stomach with bony metastases; the other is metastatic carcinoma of the liver of undetermined origin.

The cases above presented and the cases cited from other sources more or less demonstrate that the increase in the acid phosphatase in the blood could very well be produced by pathological conditions other than prostatic carcinoma. The theoretical basis for this assumption is not yet clear, but careful search for clinical cases and improvement of laboratory techniques may resolve this problem.

DR. EGNER: I only know of one reported case in the literature of carcinoma of the stomach producing an elevated acid phosphatase. That patient had an elevation of the alkaline and acid phosphatases and showed widespread metastatic spread to lymph nodes and bone. I have had the opportunity to discuss this problem with Dr. Herbert Brendler of Bellevue Medical Center. He has heard about isolated cases in which the acid phosphatase was elevated and the patients had metastatic carcinoma other than prostatic, i. e., breast, stomach, and pancreas.

DR. TORRES: Could this patient have had a spontaneous gastrointestinal or esophageal hemorrhage? These conditions sometimes occur in an older person, but in this particular patient, I am ruling it out because it does not have strong clinical support.

Did this patient have an extrahepatic portal obstruction secondary to extrinsic pressure from a retroperitoneal mass? This is a definite possibility. There are several possibilities that could produce portal or splenic vein obstruction, such as carcinoma of the stomach infiltrating poste-

riorly, a pancreatic tumor or cyst, a lymphomatous growth retroperitoneally, or metastatic growths in lymph nodes.

Whatever might be the cause or causes of the portal or splenic obstruction, I believe there is sufficient evidence to support this diagnosis. The upright film of the abdomen reveals what appears to be a mass in the left upper quadrant, and a slightly enlarged spleen. Anemia and thrombocytopenia were present. The latter might be explained on the basis of hypersplenism and/or infiltration of the bone marrow. The sudden onset of hematemesis could be attributed to rupture of esophageal varices.

Could the mass in the upright film represent a lymphomatous growth? The absence of lymphadenopathy in the cervical, axillary, inguinal and mediastinal areas mitigates against this diagnosis. (Liver and splenic enlargement are not too infrequent, however.) The presence of irregular fever, leukocytosis, eosinophilia, peculiar bronze pigmentation of the skin, anemia, splenohepatomegaly, and cachexia lend support to the diagnosis of Hodgkin's disease. Pruritus is frequently an outstanding symptom of the disease. The incidence of Hodgkin's is greatest in the third and fourth decades of life. Abdominal Hodgkin's disease is very rare.

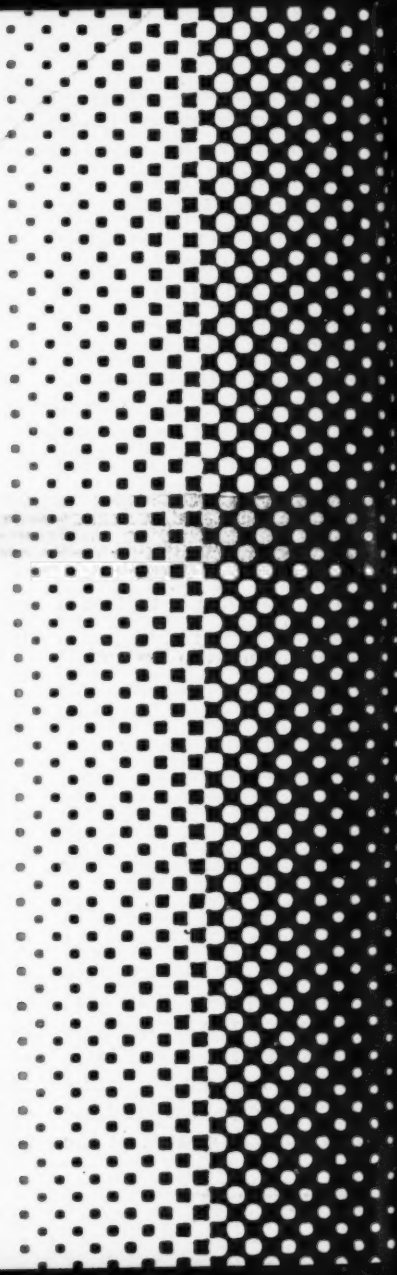
Could the above mentioned mass represent a pancreatic cyst or tumor? The diagnosis is difficult clinically. The laboratory findings are not of great value unless the disease has advanced to such a degree that there is pancreatic necrosis producing elevation of the blood amylase. It is important, however, to do an upper GI series in the hope that it may furnish evidence of a derangement of the normal anatomic relationships of the adjacent structures. Exploratory surgery is almost always the key to diagnosis.

Remote

Laennec's cirrhosis, to my way of thinking, is also a remote possibility. While it is true that this patient gave a history of excessive consumption of alcohol and the odor of alcohol was detected on his breath at the time of admission, this should not imply necessarily that he had portal cirrhosis. The liver enlargement may have been a reflection of the emaciated state of this man or chronic passive congestion secondary to cardiac decompensation. No mention was made of the consistency, or whether or

a spreading pattern of therapeutic success

A rewarding approach to the emotional and somatic manifestations of anxiety, agitation and tension, Librium therapy is now being utilized in many different areas of general practice. Approximately 3.5 million Librium-treated cases, as well as more than 70 published reports, offer testimony to this spreading pattern of therapeutic success. They corroborate observations, gained over a span of more than three years, that Librium is pharmacologically and clinically **in a class by itself.**



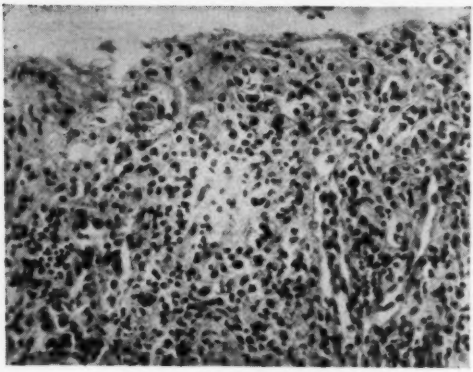


Fig. 1 High power microphotograph shows infiltration of stomach serosa by anaplastic adenocarcinoma.

not the liver was tender on palpation. The omission of liver profile tests, the absence of biliary colic, jaundice and indication of changes in the different tests above mentioned, tentatively rule out this diagnosis.

Could this patient have had mild cardiac decompensation secondary to arteriosclerotic heart disease? The presence of shortness of breath and moderate orthopnea for the last six months associated lately with 1-2+ ankle edema, give strong support to this impression. The congestive changes in the lungs, as noted on the chest films, the hepatomegaly, and the EKG changes, lend additional confirmatory evidence. The presence of pulmonary emphysema might serve as a contributing factor in the development of this condition.

Clinical Diagnoses:

1) Chronic alcoholism

2) Arteriosclerotic heart disease

3) Carcinoma of the prostate with widespread metastases

Dr. Torres' Diagnoses:

1) Carcinoma of the prostate or stomach with widespread metastases

2) Mild cardiac decompensation secondary to arteriosclerotic heart disease

Pathology

DR. PUPINO: At autopsy the primary pathology was in the stomach which showed extensive involvement of the pyloric region by an infiltrating lesion. Microscopically (Fig.1) this was an anaplastic adenocarcinoma which infiltrated to the serosa and presented as sheets of oval to poly-

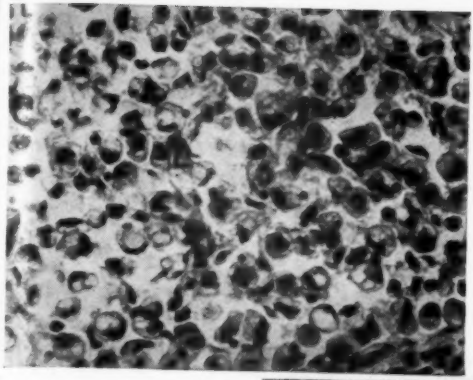


Fig. 2 Gastric lesion showing prominent signet-ring forms.

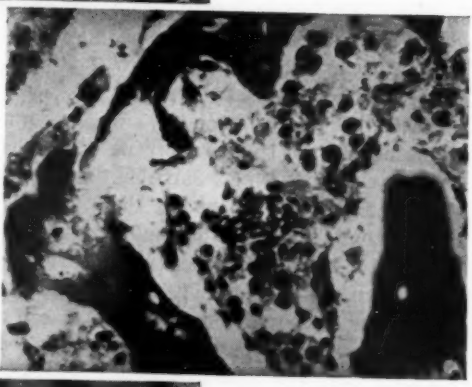


Fig. 3 Postmortem of bone marrow showing diffuse metastatic involvement.

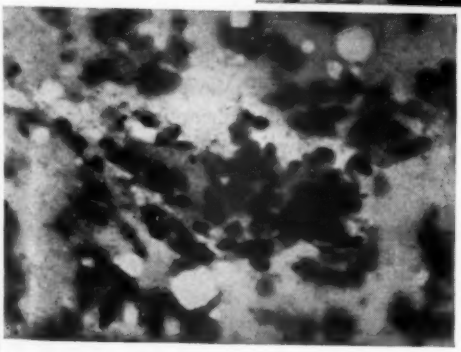


Fig. 4 Premortem smear showing a clump of atypical cells.

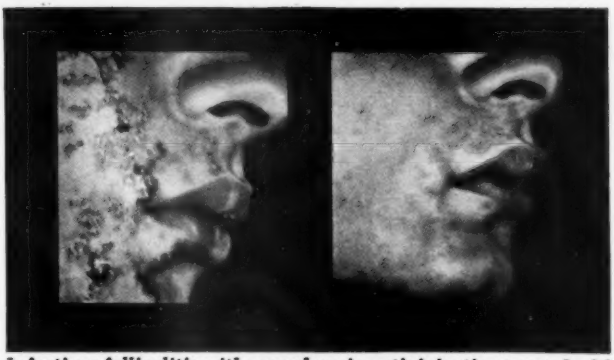
hedral cells with large, irregular hyperchromatic nuclei and vacuolated cytoplasm with prominent signet-ring forms (Fig. 2). Metastatic involvement of the pyloric, periaortic and scalene lymph nodes together with extensive involvement of the thoracic and lumbar vertebrae were also noted (Fig. 3).

Grossly and microscopically, the prostate gland was not unusual. The lungs showed acute and chronic bronchopneumonia, bronchiectasis and fibrosis and emphysema. Cardiac hypertrophy considered to be secondary to chronic anemia. The other organs were essentially unremarkable. As noted in the protocol, the premortem marrow aspiration showed a clump of atypical cells in the smears (Fig. 4). The marrow units were sparse and showed erythrocytic hyperplasia. Dr. Bien, would you care to discuss the acid and alkaline phosphatase as related to this case?

DR. BIEN: The specificity of various substrates for phosphatase varies widely. In those institutions where the Bodansky procedure is followed, the substrate is sodium-beta glycero phosphate, and there is a minimal false elevation of the acid phosphate activity by high alkaline phosphatase activity. In the Bodansky method, there is a large blank reducing the accuracy since small amounts of acid phosphatase are present. The most frequently used substrate is sodium phenylphosphate, which is the substrate for the King Armstrong method and various modifications, such as the King Kind method which we employ here.

Since sodium phenylphosphate is less specific, there may be moderate elevation of the acid phosphatase secondary to high serum alkaline phosphatase activity. Under these circumstances, elevated acid phosphatase values have no significance. A simple method for eliminating this source of error is the incubation of the serum with absolute alcohol prior to determining the acid phosphatase activity; the activity of prostatic origin being alcohol labile.

Other phosphatase substrates include phenophthalein mono phosphate and 2-naphthyl phosphate. The literature states that 2-naphthyl phosphate is highly specific for acid phosphatase.



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Books for Boards

Saul Kuchinsky

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GENERAL

Bierring, W. L., *ed.* **Rypin's Medical Licensure Examinations.** 8th ed. 1957. Lippincott.

Flippin, *ed.* **Goepp's Medical State Board Questions and Answers.** 9th ed. 1957. Saunders.

ANATOMY

Edwards, L. F. **Concise Anatomy.** 2nd ed. 1956. Blakiston.

Johnston, T. B. **A Synopsis of Regional Anatomy.** 8th ed. 1957. Lea & Febiger.

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McGregor, A. L. **A Synopsis of Surgical Anatomy.** 8th ed. 1957. Williams & Wilkins.

Mitchell, G. A. G. and Patterson, E. L. **Basic Anatomy.** 1954. Williams & Wilkins.

Patten, Bradley M. **Foundations of Embryology.** 1958. Blakiston.

BACTERIOLOGY

Lamanna, Carl and Mallette, M. Frank. **Basic Bacteriology.** 2nd ed. 1959. Williams & Wilkins.

Stewart, F. S. *ed.* **Bigger's Handbook of Bacteriology.** 7th ed. 1959. Williams & Wilkins.

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Goldman, Mervin J. **Principles of Electrocardiography.** 3rd ed. 1960. Lange.

Grant, Robert P. **Clinical Electrocardiography,** spatial vector approach, 1957. Blakiston.

Levine, Samuel A. **Clinical Heart Disease.** 5th ed. 1958. Saunders.

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Sobotka, Harry and Stewart, C. P., *ed.* **Advances in Clinical Chemistry.** Academic. vol. 1, 1958; vol. 2, 1959; vol. 3, 1960.

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Lewis, George M. et al. **An Introduction to Medical Mycology.** 4th ed. 1958. Year Book.

ABOUT THE AUTHOR

A graduate of New York University and Western Reserve University Library School, the author has been a school teacher, postal clerk, newspaper reporter and, since 1948, professional librarian. He was circulation librarian at the Union Theological Seminary (Protestant) from 1950 to 1953, organized or reorganized six Jewish Center libraries in New York from 1951 to 1956. Medical librarian of the Jewish Hospital of Brooklyn from 1953-1959, he is presently librarian at Montefiore Hospital Library, Manhattan. Mr. Kuchinsky has examined 21 hospital medical libraries in New York and some 50 university and public libraries from coast to coast.

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1. Baer, S., et al.: J.A.M.A. 167:704, June 7, 1958. 2. Moser, K. M.: Disease-a-Month, Chicago, Yr. Bk. Pub., Mar., 1960, p. 13.

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Lewis, George M. **Practical Dermatology.** 2nd ed. 1959. Saunders.

Moss, Emma and McQuown, Albert L. **Atlas of Medical Mycology.** 2nd ed. 1960. Williams & Wilkins.

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Krupp, Marcus A. et al., *eds.* **Physician's Handbook.** 11th ed. 1960. Lange.

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Gardner, Ernest. **Fundamentals of Neurology.** 3rd ed. 1959. Saunders.

Manter, John T. **Essentials of Clinical Neuroanatomy and Neurophysiology.** 1958. Davis.

OBSTETRICS

Bourne, Aleck W. **A Synopsis of Obstetrics and Gynecology.** 12th ed. 1959. Williams & Wilkins.

Litzenberg, Jennings C. and McLennan, Charles E. **Synopsis of Obstetrics.** 5th ed. 1957. Mosby.

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OPHTHALMOLOGY

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Perera, Charles. **May's Manual of Diseases of the Eye.** 22nd ed. 1957. Williams & Wilkins.

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Strecker, Edward A. **Fundamentals of Psychiatry.** 5th ed. 1952. Lippincott.

Valentine, Max. **An Introduction to Psychiatry.** 1955. Williams & Wilkins.

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PUBLIC HEALTH

Mustard, Harry S. and Stebbins, Ernest L. **An Introduction to Public Health.** 4th ed. 1959. Macmillan.

Smillie, Wilson G. **Preventive Medicine and Public Health.** 2nd ed. 1957. Macmillan.

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Welch, C. Stuart and Powers, Samuel R., Jr. **The Essence of Surgery.** 1958. Saunders.

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Dodson, Austin I. and Hill, J. Edward. **Synopsis of Genitourinary Diseases.** 6th ed. 1956. Mosby.

Smith, Donald R. **General Urology.** 2nd ed. 1959. Lange.

ANNUALS

Many exam reviewers find the recent volumes of the Year Book series, Year Book Publishing Company, just to their taste. These annuals appear in the fields of medicine, obstetrics and gynecology, general surgery, pediatrics, radiology, drug therapy, ophthalmology, ear, nose and throat, urology, neurology, psychiatry and neurosurgery, dermatology, endocrinology, orthopedics and traumatic surgery, cancer, and pathology and clinical pathology. They are collections of abstracts of the year's leading journal articles.

Another such annual, but one edited in running commentary rather than as formal abstracts, and carrying extensive bibliographies, is the Annual Reviews series, Annual Reviews, Inc. Volumes are issued in the fields of entomology, psychology, physiology, pharmacology (starts April 1961), medicine, plant physiology, biochemistry, physical chemistry, microbiology and nuclear science.

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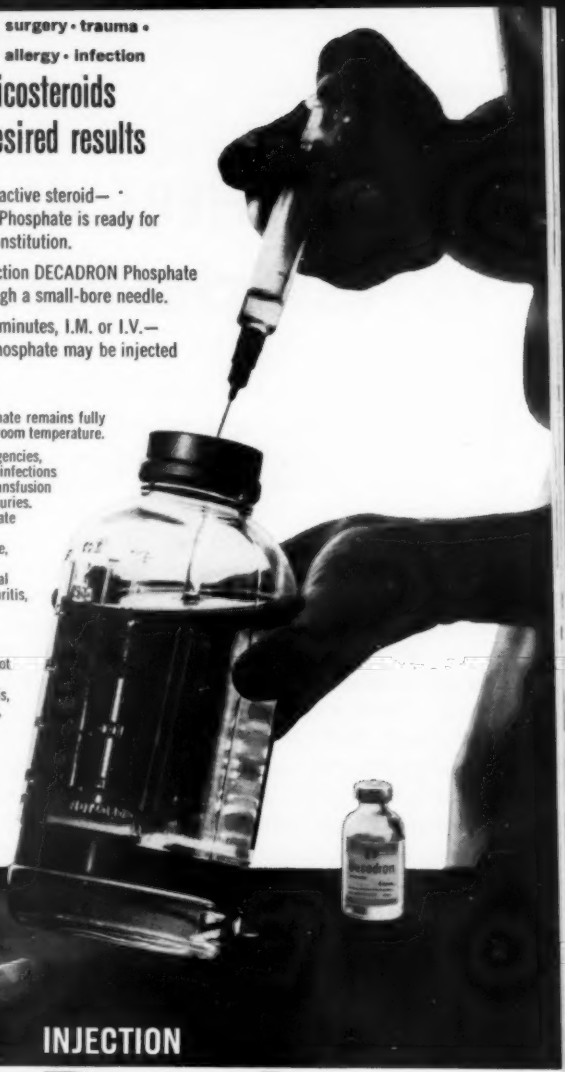

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IS THERE AN **Esperantist**

Even in his native land a doctor can have language troubles. I'm from England. And, as small a country as England is, there are baffling differences in dialect. The London physician may hear his Yorkshire patient say, "Put twood in thoil," which sounds like an injunction to stir up some kind of mess, but really means, "Put the wood in the hole." And what exactly does *that* mean? Why "shut the door!" of course.

However, it's the patient from a foreign country who can be the real problem. When you try to take his history, he simply sits, smiles politely, nods his head, and occasionally grimaces and gestures.

Sometimes he will emit a flood of verbiage, an incomprehensible torrent of language—Magyar or Tagalog—or worse, a version of English which is even less comprehensible and much more misleading.

I remember a patient who had no English but claimed to be able to speak German, Polish, and Russian; but doctors who spoke German and Polish could not communicate with him. Finally, an attempt was made to reach him by a Russian-speaking patient who chanced to be in the clinic at the time. That solved it and one patient took the other patient's history.

Interpret

Some patients bring their own interpreter, like the Belgian lady whose friend came along. When the doctor asked a question, the friend simply repeated it *in English,* but much louder. It seemed to work.

Then there was my Italian patient with an injured shoulder. On his second visit he brought a

IN THE HOUSE?

D. M. Jackson, M.B.

***Says the author:* "This is more frivolous than most of the articles you publish. But it is written by a resident for residents . . ."**

piece of paper measuring about 1 x 5 cm., and said: "My friend he write this." It bore the terse suggestion: "TO TWINGE AND TO PUSH PLEACE."

Abroad

The doctor who goes abroad is, of course, asking for trouble. He will have difficulty in understanding not only his patients but also his colleagues. Thus, I have the profoundest admiration for the many residents from Continental Europe and the Orient who arrive in America almost totally innocent of any knowledge of English and within a couple of months are fluently discussing (in English) abstruse problems of electrolyte chemistry or radiotherapy physics—and as likely as not correcting (with the utmost politeness) the grammar of the natives.

My admiration is all the deeper —for I sometimes still have language difficulties after a couple of years in the States, even though I was born and raised in England (also an English-speaking country).

I feel the need of a little book, such as tourists use in Europe; but it would doubtless contain only the American translation of phrases of rather limited utility, such as "Waiter! The backgammon board!" and "Lo, the postilion has been struck by lightning."

Even where the words used are

the same, there is much for the British resident to learn. For instance, there is a free and easy manner of word use common in American hospitals. Soon after my arrival I heard the gentleman who emptied the garbage cans (dustbins, to me) call out "Hi, girls!" to the director of nursing and her deputy. Now in England if *anyone,* from the chief of the medical service down, had addressed the "Matron" in those terms there would have been an explosion to rock the hospital. I expected the poor man to be struck down by a torrent of ladylike but no less shattering invective, or at least shrivelled by chill stares. But the august ladies merely smiled and nodded to him.

On the other hand, when I said "Hi, Sister" to a Head Nurse—for that would have been her title in England—she thought I was being fresh. Then there is the general use of "Sir," which is reserved in Britain for very senior people.

(There was a story in the *Lancet* of an English house officer who told a visiting American nurse that she need not call him "Sir," and she said, "O.K., you lousy bum.")

Floors and food

One thing that is hard for the visitor from Britain to grasp is the truly logical way in which floors are numbered in the U.S. In England, the first floor is not the first floor you come to but the first floor up from the ground; the ground floor being called the ground floor. It is a pleasant surprise here to set out for the second floor and find it only one flight up.

Another confusing thing is abbreviated dates. In Britain, 4/7/60 is the Fourth of July, not the seventh of April. (I'm told that the U.S. Army follows the British practice; do you wonder I'm confused?) And speaking of dates, aside from the calendar ones, a date to me is a fruit, or

ABOUT THE AUTHOR

Dr. Jackson was graduated from St. Mary's Hospital Medical School, University of London, in 1950. He has been house officer in medicine and surgery at various hospitals in Britain and the United States. He served for two years in the Royal Air Force and 19 months on the editorial staff of a medical journal in England. He is at present a resident in radiology at Mount Auburn Hospital, Cambridge, Mass.

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occasionally an appointment. If someone asks "May I bring my date to the party?" it sounds to me as though he wants to make sure of getting enough to eat—especially if he brings a "heavy date," which must be one of those legendary super-fruits from Texas (no pun intended.)

Double meaning

This brings us to the big trouble as regards language, which is not the use of different words for the same thing—you easily get into the habit of saying "elevator" and "mineral oil" instead of "lift" and "liquid paraffin"—but rather the use of one word to express two different meanings, for instance, floor and tray. To me a place containing a definite group of patients, cared for by a definite group of nurses, is a ward, whether it is one great big room (as it often is in Britain) or a collection of rooms of assorted sizes. But here such a unit is often called a floor, which is fine, except that there may be two or more of them on, say, the second floor.

Moreover, I must say it bothers me to pick up a phone when it rings and hear a voice ask, "Is Doctor Brown on the floor?" I imagine that unlucky physician lying incapacitated through illness or drink. It calls to mind the old joke about the man passing around the food at a garden party: "Have a roll, Duchess?" "No, thank you, I'm quite comfortable standing here."

Feeding time

Another difficulty springs from the way in which patients are fed. In Britain, dinner for the whole ward (floor) usually arrives in bulk and, with some ceremony, is dished out by the Sister (Head Nurse) as if by a hostess. But here, at least in some hospitals, each patient has a trayful of food

independently prepared in the diet kitchen, and the whole meal is referred to as his tray. Before I knew this I was surprised to hear a physician inquire in matter-of-fact tones about a patient, "Did he eat his tray?" I had visions of a ravenous man, perhaps a victim of thyrotoxicosis or some gargantuan adult variant of pica, eating food, paper napkins, dishes, cutlery (flatware), and finally in desperation his tray.

No doubt an American resident in England would be equally shocked to hear his chief inquire about the emergency case of perforated ulcer, "Has the patient gone to the theatre?" Surely he is in no shape to go to a movie! Or perhaps he is a crazy actor, who, muttering, "The show must go on," has dragged himself back to the stage to save the day and cheat his understudy out of a big chance. But of course "theatre" is an old English survival meaning "operating room" — a survival perhaps from the days when a big audience would gather to watch some celebrated surgeon perform a famous ninety-second amputation, or Caesar Hawkins implanting beans in the back to cause laudable pus to form in the hope of relieving Pott's disease, or more recently some other master stealing the thyroid.

Abbreviations

But there is no confusion like the confusion aroused by abbreviations. There are even abbreviations used by only one person. I once found a note in a chart that read "HNWG." If you can't guess (I couldn't) the footnote will help you.* There are the abbreviations having two or more meanings. If a patient is labelled C.T., does he have cerebral tumor or coronary thrombosis? Probably the former, for a coronary case is more often labelled M.I.; but then that might be confused with mitral incompetence, just as M.S. can mean mitral stenosis or multiple sclerosis, A.I. aortic incompetence or artificial insemination, and C.D.H. congenital disease of the heart or dislocation of the hip.

But these hazards, though bad enough, are international. There are others more likely to trip up the foreigner. An American in England might be surprised to meet a venerable gentleman with low back pain and be told that the diagnosis is P.I.D. — which over there stands invariably for prolapsed (ruptured) intervertebral disc. Again, charts in England are strewn with the initials

* Has Not Worn Glasses.

S.O.B.; this is not a Trumanesque assessment of the patient's character but an indication that he is short of breath.

I was just as surprised as our hypothetical American in England when I read, in a U.S. medical newspaper, the headline "P.R. for M.D.s." Now in British medical jargon an M.D. is either a mental defective (or, to use the newly favored term, a "person of severely subnormal personality"), or else someone with a higher degree, usually in internal medicine (the common or garden qualifying degree is M.B. P.R. stands for per rectum, and is used for administration of drugs, but chiefly for digital examinations).

Those given to the use of slang will say "do a P.R.," meaning "examine the rectum." I soon realized that my mental picture of morons or eminent internists lining up for examination was in error, but it took me some minutes of brainracking to realize that P.R. also stands for public relations (not to mention Puerto Rico). In British nonmedical jargon P.R. has yet another meaning—*proportional representation*—which is a method, proposed by the Liberal Party, of electing M.P.s.

M.P.s, by the way, are not military police, but members of parliament; at which point I give up. Is there an Esperantist in the house?

"I said her case history card. This is a recipe for curried shrimp."

Frederic B. Champlin, M.D.

Guest Editorial

The Proper Study of Mankind Is Still Man

To date no apparatus or chemical test has been devised which has eliminated the need for an accurate and, in most instances, detailed history. Many physicians, I am sure, spend an inappropriate amount of time composing pages of orders for laboratory examinations and less effort seeking information from a patient. Consequently, it appears that the interest of such doctors is mainly biometrics rather than human behavior and disease. Patients are referred to as "poor historians," whereas all too frequently, it is the physician who lacks the ability, tact, and medical knowledge to elicit the pertinent biographical date from these "poor historians."

The time to develop skill in the art of taking an accurate history is during an internship and residency. This ability is enhanced by the physician's increasing knowledge of diseases and of the complexities of human behavior. In most instances, the amount of time spent listening to the patient and interjecting a few pertinent questions yields information which may implicate more than one disease entity. The functional overlay should be recognized and an attempt made to correlate this with the presenting organic

F. B. Champlin, M.D.
Director of
Professional Services
and Education,
Meadowbrook
Hospital

pattern. A knowledge of an individual's strivings, ideals, and standards is important from the standpoint of the dynamics of certain illnesses and the attitude of the patient toward his illness.

If an accurate history is to be obtained, it is important for a physician to gain the confidence of the patient, and to listen as though nothing else mattered. A patient's fears and feelings of guilt or inadequacy may obscure the basic problem, making it difficult for the inexperienced or hurried physician to uncover the facts necessary for the formulation of differential diagnoses.

Pain in the chest or abdomen, for example, may reflect the coexistence of more than one illness. The correct diagnoses will depend on subtle variations of questioning in order to separate one type of pain from another. It is inexcusable to submit a patient to an extensive cardiovascular work-up, and possibly treatment, when a little more time and effort on the part of the examiner would have revealed symptoms pointing to a diagnosis of hiatus hernia and/or an intercostal neuritis.

Time is of the essence in a busy hospital or private practice. However, the successful physician learns to spend his time in a manner which will yield the greatest amount of information without conveying the impression of working under pressure. No laboratory tests can ever supplant a clinician's knowledge, skill, and interest in the individual patient's problems. A good history will indicate the minimal number of tests necessary to support a diagnosis and will enhance the joy which attends the practice of good medicine.

Meadowbrook

Hospital NASSAU COUNTY, N. Y.

Meadowbrook Hospital in Nassau County, N. Y., is the major medical facility and the only county general hospital in an area which has led the nation in population gains in recent years.

Located on Long Island 30 miles from Manhattan, the hospital was founded 25 years ago to care for the county's service cases. The population then was 600,000. It remained relatively stable until the exodus to the suburbs hit full stride following World War II

Veterans just starting their families streamed to Long Island where land and housing were available. Seemingly overnight, potato fields became towns and cities. The largest of these fledgling communities, Levittown, where

Founded 25 years ago, Meadowbrook Hospital is the only county general hospital in an area of tremendous population gains. To keep pace with this growth, the hospital continues to expand its physical plant and educational programs. It offers training to 40 interns and 77 residents in 12 specialties.

17,000 homes mushroomed within a period of a few years, is only a short drive from Meadowbrook.

With its population doubling in the past ten years, Nassau County today has 1,300,000 residents. To keep pace with this tremendous growth, Meadowbrook has had to expand its facilities. Since its founding, the hospital has almost tripled its bed space. Today it has 650 beds and 44 bassinets. Recently the building which houses the psychiatric unit was enlarged to increase its capacity to 75 beds, and planned expansions in the near future include more space for the department of pathology and laboratories, and for the installation of a supervoltage x-ray therapy unit.

In 1959 the hospital admitted 18,341 patients and treated 29,099 sick and injured in its emergency rooms. Of the latter, some 22,000 were victims of accidents, which points up another aspect of the hospital's environment. It is situated in an area of busy parkways and heavily traveled roads. Daily, cars stream to and from New York City, and during the summer there is the added burden of thousands of vehicles headed for Long Island's famous beaches. As a result, as many as 150 trauma cases will flow into the emergency ward in a single day.

Education

The hospital's physical expansion has been accompanied by a similar growth in its education and training programs. Today the house staff includes 40 interns on a rotating basis and 77 residents. There are 509 attending physicians, a number of whom hold faculty appointments at the various New York medical schools. Meadowbrook is affiliated with the New York University-Bellevue Hospital Medical Center through the Regional Hospital Plan.

Full-time directors head the departments of radiology, anesthesiology, physical medicine, pathology (which includes hematology and biochemistry), cardiopulmonary laboratory, and the divisions of internal medicine, pediatrics, psychiatry and family practice.

The hospital also provides a school of medical technology and an affiliation for the students of the Adelphi College School of Nursing.

Programs

Postgraduate education includes a one-year, rotating internship, and approved residencies in internal medicine, general surgery, plastic surgery, urology, pediatrics, obstetrics and gynecology, oral surgery, orthopedics, radiology and pathology. The programs are columnar in structure.

Approval for two other programs, in anesthesiology and family practice, is anticipated. The residency in family practice reflects the needs of the area, with its heavy concentration of young, growing families. There is an adequate number of specialists in the county, but more young doctors are required to care for the family's general health needs.

Thus the hospital has set up a one-year family practice residency which follows a one-year

during hospitalization and throughout convalescence

SUSTAGEN®

Complete therapeutic nutriment

to supply all or part of the patient's nutritional requirements

in the hospital...

By the time a patient reaches the hospital—whatever his illness—undernourishment is sometimes a complicating factor. To overcome the problem, Sustagen offers a therapeutic diet of carefully controlled, essential nutrients[1,2]—ideal for tube feeding,[1] palatable in beverage form.[2] This diet helps promote good nutrition, hasten convalescence.[1,2]

in the home...

The convalescent who continues to receive Sustagen at home is more likely to hold or increase his nutritional gains. Each glassful you specify adds 390 calories to his diet, including 23.5 Gm. protein, 3.5 Gm. fat, and 66.5 Gm. carbohydrate—plus important quantities of all essential vitamins and minerals.

references
(1) Pareira, M. D., *et al.*: J.A.M.A. *156:* 810-816 (Oct. 30) 1954. (2) Winkelstein, A.: Am. J. Gastroenterol. *27:*45-52 (Jan.) 1957.

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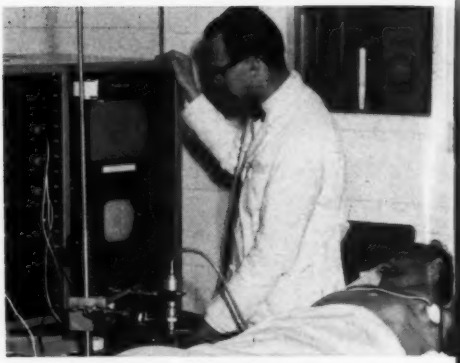
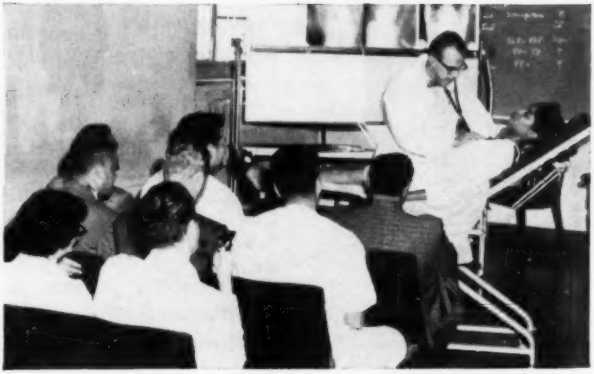
Mead Johnson Laboratories

Symbol of service in medicine



Chief of the cardiopulmonary laboratory takes phonocardiogram, and (below) presents a patient, whose lab workup has been completed, to attending cardiologists and residents at clinical problem conference.



rotating internship. In the program, residents will rotate through medicine, including psychiatry, adult and pediatric contagion, obstetrics, and pediatrics. The training will stress outpatient clinic experience. The program begins this July, with places for four residents.

Medicine

The division of internal medicine is directly responsible for from 225 to 250 patients daily and in 1959 treated 4,664 patients. The first year of the residency program is devoted to intensive training in patient care, the supervision of interns as-

MEADOWBROOK HOSPITAL

George C. Erickson, M.D., Medical Superintendent

SERVICE	DIRECTOR	RESIDENCIES	YEARS
INTERNAL MEDICINE	Abraham Freireich	18	3
OBSTETRICS & GYNECOLOGY	Gerald T. Lilly	8	4
ORTHOPEDICS (traumatic)	William P. Bartels	4	6 mos.
ORAL SURGERY	William F. Harrigan	2	1
PATHOLOGY	Vincent S. Palladino	8	4
PEDIATRICS	Eugene A. Stanchi	6	2
PLASTIC SURGERY (3 years approved general surgery residency prerequisite)	Leonard R. Rubin	2	2
PSYCHIATRY	Reginald R. Steen	2-3	1
RADIOLOGY	Herbert R. Zatzkin	6	3
SURGERY	John N. Shell	12	4
UROLOGY (one year internal medicine or general surgery residency prerequisite)	Carl J. Schmidlapp	3	3
ANESTHESIOLOGY*	Irving G. Weinberg	2	2
FAMILY PRACTICE*	Frederic B. Champlin	4	1

*Approval Pending

signed to a section, and responsibility to the third year resident in charge of the particular unit. The second year is devoted to training in the basic sciences and in the subspecialties of internal medicine. On a rotating basis, the resident is assigned for six months to the department of pathology (including clinical pathology), two months in the department of radiology, and four months in the specialty clinics.

The third year resident is the chief resident in his particular assignment and is responsible, for periods of two months, for the sections on male and female medicine, adult contagion, interservice consultations, cardiopulmonary laboratory, neurology and psychiatry. The chief resident in any of the various sections has full responsibility but is advised by the attending staff and the full-time director.

A weekly seminar is held, with


To anticipate the harvest you must consider the seed from which the plant is grown.
QUALITY.
It is human nature to ask: "What's behind it?" The fact that our nation's doctors stand behind Blue Shield, through their local medical societies, is certainly an important reason for its widespread acceptance. One doctor summed it up this way: "The public will have faith in Blue Shield so long, and only so long, as we the doctors have faith in it and continue to endorse it."
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The program
WEHR

sessions devoted to journal clubs, basic sciences, and an intensive study of electrocardiography. These meetings are led by the director of medicine.

Surgery

Three residents are accepted each year for the full four year approved program. A limited number of residents needing one, two, or three years of general surgical training prior to completion of training in a surgical subspecialty are also accepted.

The residency program encompasses a three-phase activity: inpatient care, surgical clinics, and daily ward rounds; basic sciences, including anatomy, physiology and pathology; weekly and monthly surgical conferences and a weekly surgical journal club.

Junior assistant residents rotate for three month periods through the genitourinary and gynecological departments, orthopedic (traumatic) department, female and male surgical services. While on male and female surgery, the resident receives special instruction in plastic, neurologic, traumatic, thoracic and cardiovascular surgery, and proctology. Three assistant residents each spend six months in pathology.

The chief residents are given ample opportunity for independent thought and action in the operating room. The available cases are more than sufficient in number and diversity to provide the resident with a good background in operative surgery.

Clinical research is a continuing program for comparing results of different accepted methods, surgical procedures, and drugs. Research as well as procedures designed to familiarize the resident with the use of the heart-lung machine, the perfusion pump and special area refrigeration techniques, are conducted in the animal laboratory.

A total of 1,622 major and 7,198 minor operations were performed in 1959.

Ob-Gyn

Ward and clinic assignments in obstetrics and gynecology are augmented through an affiliation with a nearby private general hospital. Thus the department is involved in the treatment of large numbers of private and service patients. The annual volume amounts to over 4,500 obstetrical patients and 1,500 gynecological operations.

The scope of the four-year residency program includes training in female surgery, medicine and pathology. Responsibility for the

Chart rounds and bed rounds with chief of pediatrics form integral part of house staff training program in the specialty.

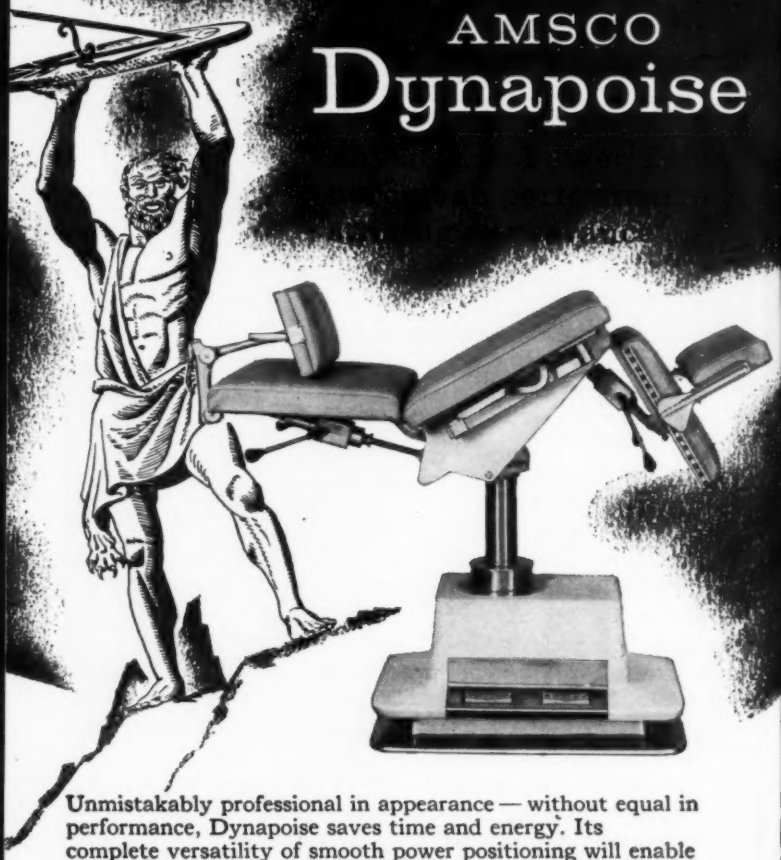
care of obstetrical and gynecological patients is increased gradually. In the fourth year, the resident has the opportunity to participate in the tumor service in the diagnosis and therapy of malignancies.

Pediatrics

An approved two-year program in pediatrics provides residents with graded responsibility. One full-time and three associate directors head a teaching staff made up of actively practicing pediatricians, 59 of whom are diplomates of the American Board of Pediatrics.

Residents rotate through the general pediatric wards, communicable disease pavillion, and the premature center. Daily ward rounds with attending physicians and conferences with the directors are part of the teaching program. Opportunities for diversi-

AMSCO Dynapoise

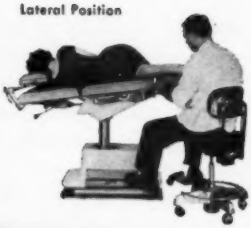


Unmistakably professional in appearance — without equal in performance, Dynapoise saves time and energy. Its complete versatility of smooth power positioning will enable you to examine and treat **MORE** patients per office hour. Your patients will be more comfortable, relaxed, and responsive . . . and **YOU** will be less tired at the end of "hours."

This new powerized Examining and Treatment Table for office and clinic, is a logical projection of the continuing research that produced, and is producing, the world's most favored surgical operating tables.

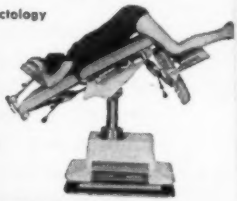
Dynapoise is clearly destined to become "standard" for modern medical offices. May we suggest that you investigate its physician-oriented advantages . . . now? Mail the coupon for eight-page Brochure PD-703.

Low Position



Lateral Position

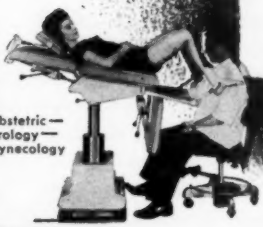
Pediatric



Proctology

Practice
torium
Booth 38-39

Ear,
Throat



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Name

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fied and specialty experience are provided by the following clinics: general pediatric, well baby, allergy, pediatric cardiology, dermatology, endocrinology, hematology, nephritis and nephrosis, neurology, and rheumatoid arthritis.

Pathology

Meadowbrook's program in pathology is approved for four years of residency training. Both pathologic anatomy and clinical pathology are covered in each year of training. The program for each year comprises three months of autopsy service, three months of surgical pathology (including cytology) and six months of clinical pathology.

The clinical pathology schedule is generally split up as follows: biochemistry, 30%; hematology, 20%; blood bank, 10%; bacteriology, 20%; parasitology, 5%; toxicology, 5%; serology, 10%.

Emphasis is placed on continuous and integrated training in both pathologic anatomy and clinical pathology, and ample time is allowed for the study of all interesting material passing through the laboratory, regardless of a resident's assignment at any given time. In addition, clinical correlation is encouraged.

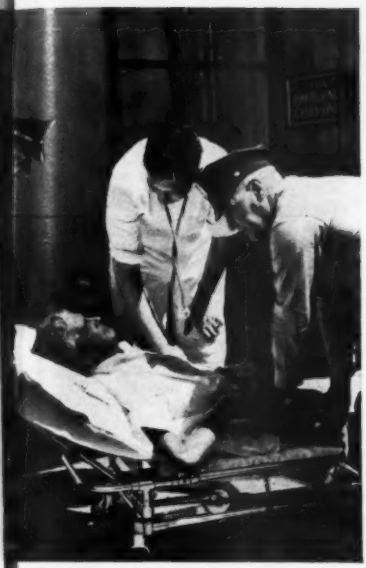
The laboratory, which is shared with the Nassau County Medical Examiner's Office, is housed in a modern, three-story building. The staff includes five full-time physicians, four of whom are diplomates of the American Board of Pathology, and two part-time physicians. The technical staff consists of 44 full- or part-time technicians.

The laboratory has its own library of current journals and reference books, and a filing system of pathologic diagnoses and teaching collections of pathologic material. The latter include approximately 2000 slides and commentaries of numerous conferences of national importance.

In addition to attending numerous hospital conferences, the pathology department holds its own daily gross conferences, weekly clinical-pathological conferences, surgical slide conferences and journal club and a monthly or bi-monthly topic club.

Radiology

The three-year approved residency in radiology includes diagnostic roentgenology during the first two years and therapeutic radiology during the third year. A detailed program provides time for observation, active par-



n a peak day, Meadowbrook's emergency rd may handle as many as 150 patients, ny of them victims of auto accidents.

ticipation in fluoroscopy, film reading, and conference presentations. There are special departmental teaching sessions and conference assignments.

In addition, residents participate in therapy topic seminars, follow-up conferences, teaching file review, courses in radiation physics (at Columbia University) and isotopes (at New York University-Bellevue Medical Center), journal clubs, and conferences for interns.

Library

The medical library is open daily from 9 AM to 10 PM. It is staffed by full-time librarians and contains 1200 volumes and 5000 bound journals. A total of 217 journals are regularly received and 270 new books purchased annually. In addition, loans are made from other medical libraries in the New York City area.

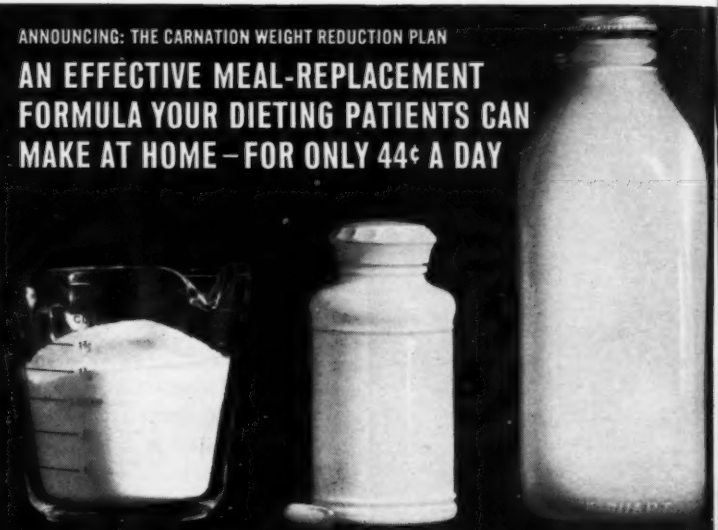
Stipends, perquisites

Monthly stipend for interns is $200 and for residents, $275. In addition, a cost of living allowance is provided, based on the house officer's number of dependents. Room, board, laundry and uniforms are provided, as is free medical care for house officers, their wives and children. Both interns and residents receive two weeks' paid vacation.

Meadowbrook's sports facilities include tennis courts, a softball field and a basketball court. Public golf courses are adjacent to the hospital grounds, and within a ten-mile radius are excellent salt-water beaches and facilities for boating and fishing. As Meadowbrook is only an hour's drive from Manhattan, the house officer can easily avail himself of the many cultural and entertainment attractions that the big city has to offer.

ANNOUNCING: THE CARNATION WEIGHT REDUCTION PLAN

AN EFFECTIVE MEAL-REPLACEMENT FORMULA YOUR DIETING PATIENTS CAN MAKE AT HOME – FOR ONLY 44¢ A DAY



1½ CUPS CARNATION INSTANT NONFAT DRY MILK

1 MULTI-VITAMIN-MINERAL CAPSULE

1 QUART FRESH, WHOLE MILK

THE CARNATION WEIGHT REDUCTION PLAN

This Plan is a new meal-replacement weight reduction regimen based on delicious milk products plus a standard multi-vitamin-mineral preparation.

Carnation's nutritionally-balanced Meal-replacement Plan supplies 1000 calories and 70 grams of high quality protein.

EASY FOR PATIENTS TO MAKE

TAKE 1 standard multi-vitamin-mineral preparation each day.

MIX one day's supply (4 glassfuls) of Carnation Plan Formula by stirring together in a container larger than a quart:

1½ cups CARNATION INSTANT NONFAT DRY MILK

1 quart WHOLE MILK

If desired, flavor with instant coffee or a variety of extracts. Chocolate flavoring adds 30 calories per teaspoonful.

OR for a Single Glass: Mix a generous ⅓-cup Carnation Instant with 1 cup whole milk.

COSTS ONLY 44¢ A DAY

The total expense for the Carnation Weight Reduction Plan – including the multi-vitamin-mineral preparation – is 44¢ a day. Compare this to the price dieters pay for the largest-selling pre-mixed product.

TASTES NATURALLY DELICIOUS

Because the Carnation Plan Formula is based on fine, pure dairy products, it has a fresh milk flavor. Patients can vary this flavor by simply adding 3 to 4 teaspoons of instant coffee, or 1½ teaspoons of any of their favorite extracts, like vanilla, per quart.

AN EFFECTIVE, FLEXIBLE PLAN

The Carnation Weight Reduction Plan provides balanced nutrition. Providing 1000 calories a day, the Plan gives the dieter 70 grams of high-quality, hunger-appeasing protein. This concentration of protein helps satisfy the appetite, and at the same time, keeps up the dieter's energy. The Plan meets the Daily Adult Requirement for all vitamins and minerals with established minimums.

The physician prescribes the multi-vitamin-mineral preparation to supply the vitamin-mineral elements outside the basic food drink. The physician may also wish to vary the number of meals the dieter replaces with the Carnation Plan Formula and the number of days the patient stays on the regimen. In this way the physician is given the opportunity to adjust the regimen of the dieter to suit the needs of each individual patient.

BULK – TO PROTECT AGAINST CONSTIPATION

Dieters can snack with low-calorie vegetables and greens like celery, cucumbers, radishes, green pepper, lettuce. These snacks are welcomed by the dieter, and they aid regularity. Coffee and tea (without sugar and cream) may be used. Plenty of water is generally recommended.

FOR ALL DIET-CONSCIOUS PATIENTS

Carnation Nonfat Dry Milk can be recommended apart from a meal-replacement diet. All patients interested in weight control can get important protein, calcium, and B-vitamins the low-calorie way. Only 81 calories in an 8-ounce glass of regular Carnation Instant Nonfat Dry Milk.

FOR CONVENIENCE: CARNATION WEIGHT REDUCTION PLAN FOLDERS FOR YOUR PATIENTS

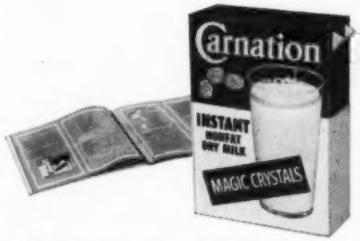
They describe the Plan fully, concisely. Give complete directions. Save your valuable time. Generous supply of folders in unique tear-out pad. Simply write to Carnation Company. Dept. WL-41, Los Angeles 19, Calif.

Four glasses of the Carnation Weight Reduction Formula and the vitamin-mineral supplement* answer the Minimum Daily Adult Requirement for all known vitamins and minerals. Besides 70 grams of high-quality protein, 100 grams of carbohydrate, and 36.8 grams of fat, the Carnation Weight Reduction Plan provides:

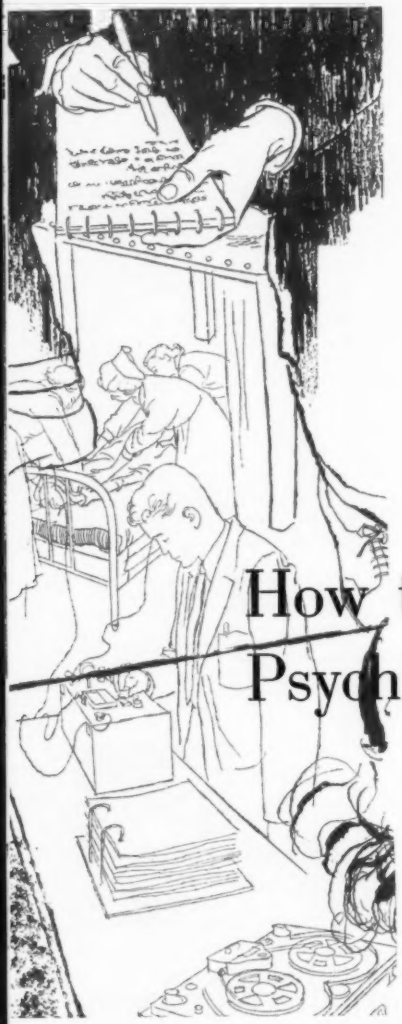
		Multiples of M.D.R.
Vitamin A	6540 Units	1.3
Vitamin D	500 Units	1.2
Ascorbic Acid (C)	76 Mg.	2.5
Thiamin (B_1)	5.77 Mg.	5.7
Riboflavin (B_2)	8.6 Mg.	7
Niacinamide	16.8 Mg.	1.6
Iron	11.8 Mg.	1.1
Calcium	2.7 Gm.	3
Phosphorus	2.1 Gm.	2.8
Iodine	0.56 Mg.	5.6
Pyridoxine (B_6)	1.42 Mg.	**
Ca Pantothenate	11.8 Mg.	**
Vitamin B_{12}	2.0 Mcg.	**
Vitamin E	10.6 Units	**
Sodium	1.1 Gm.	**
Potassium	3.0 Gm.	**
Manganese	1.0 Mg.	**
Magnesium	1.3 Gm.	**
Copper	1.6 Mg.	**
Zinc	8.0 Mg.	**
Calories	1000	

**Calculations are based on a standard multi-vitamin-mineral supplement, 1½ cups Carnation Instant Nonfat Dry Milk, and 1 quart of whole milk.*

***M.D.R. (Minimum Daily Requirement) has not been established.*



Carnation Company



What equipment is needed by the psychiatrist who is completing his residency and preparing to open an office? RESIDENT PHYSICIAN *recently put this question before a number of practicing psychiatrists. All agreed on one point: if you plan carefully, compare features and costs of similar items, you can save a considerable amount of money without sacrifice of essential equipment.*

How to Equip the Psychiatrist's Office

One of the first considerations finding genèral agreement among practicing psychiatrists who responded to the RESIDENT PHYSICIAN survey was that the decor and atmosphere of the psychiatrist's office should "reflect a mood of relaxation."

Of course, this requirement

might well apply to any physician's office. But the manner in which this relaxing atmosphere was achieved by the surveyed psychiatrists was distinctly different from what other specialists might do. And the main points were remarkably similar among all responding psychiatrists.

For example, there was agreement that the waiting room and consultation room should be "as unlike a business office as possible." Such equipment items as filing cabinets, typewriters, metal office furniture, inter-office communication units — even a telephone—were among those mentioned that should not be present in these rooms.

Homelike

Yet, the office should avoid a bare, stripped-for-action appearance, nor did many interviewed psychiatrists favor what might be termed the "clinical" decor, in which professional equipment is the dominating element.

"Homelike," was one word used by many responding psychiatrists in describing their office atmosphere. "Comfortable and relaxing," were others. Yet, most indicated strongly that they took great pains to avoid what one called "the stuffy decor of an 18th Century drawing room."

Ornate furnishings and ultra-plush appointments are often overpowering to the average patient, just as some contemporary, strictly "functional" design presents a harsh and uncompromising aspect to the patient.

Pleasant

One other important consideration. Your offices must be pleasant for *you* to work in. You should enjoy being in your consultation and treatment rooms. Therefore, consider, in choosing your furniture, the type you can be happy with.

How to get a proper balance, a relaxing atmosphere?

According to psychiatrists responding to the RESIDENT PHYSICIAN survey, choose your furniture items with a living room in mind. That is, furniture can be modern, provincial, or practically any period style (depending on your pocketbook) whatever pleases your taste—just so long as the general arrangement is in *good taste* and is not jarring to the senses.

No odd ball color combination or offbeat decorative effects. "Neither too gay nor too gray," comments one psychiatrist.

"The true measure of tasteful selection and arrangement of furniture," advises another, "is

Office equipment you'll need in private practice

This is the seventh in a series of exclusive articles on equipping your office for the private practice of your specialty. It is based solely on a survey conducted by your journal among practicing specialists. Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

when no single piece stands out from all the rest — everything should get along with everything else. That way, it's restful."

Another psychiatrist puts it this way: "When you get rich and earn a high reputation in the process, then you can put on a show. By that time, some of your patients will be coming to you expecting to be impressed with your office. You can't afford to disappoint them. But starting out, you can't afford to offend or irritate them either, because any continuing source of irritation, however minor, plays hell with the rapport."

Privacy

A second factor of importance concerns the location of the office itself. It should be kept in mind that the patient very often desires that his comings and goings be conducted in privacy, away from the public eye. This consideration cannot be ignored by the beginning psychiatrist, according to the panel of responding psychiatrists.

In this same connection, it is wise to have an arrangement whereby the patient may leave the office without going through the waiting room. Big city or small community, the need for these special considerations merit your attention.

Waiting room

The psychiatrist's waiting room need not be large. The average waiting room, according to our survey, accommodated four occupants. Again, the decor of the room should be similar to a small living room. (Here's where the doctor's wife can often offer constructive advice.)

Furniture needn't be costly to be attractive. With a little shopping, suitable chairs can be pur-

chased from $60 to $150 each. The average waiting room contained two or three chairs and a sofa. The latter can be bought new for from $200 to $350.

Carpeting

All agreed that carpeting (not linoleum, tiles, etc.) was necessary . . . if not throughout the office, at least in the waiting room and consultation room. Carpeting certainly adds dignity to any room. This, plus the quieting effect, makes carpeting well worth its greater expense as compared to other types of floor covering.

Carpet cost, of course, depends pretty much on the size of the room and the quality of the carpet. A neutral shade (easier to keep clean) of good quality wool or blended fiber would run from $8 to $13 a square yard or about $125 for a 9 x 12 room, covered wall to wall. Since the average waiting room of the psychiatrists surveyed is larger than this, the average carpet cost, plus underpad, ran to $220 among those polled.

Drapes can be expensive or inexpensive, depending on the material, labor and number of windows. An easy rule is an average of $60 per window, installed.

Tables, lamps

Two or three small tables are important since they serve the triple function of providing a base for table lamps, a resting place for magazines, and a location for ash trays. Incidentally, never mind about the cute little ash trays suitable for a woman's bridge party. Get the man-sized jobs that'll keep cigarettes from ruining your brand new tables and carpet. Tables need not be expensive. Well-designed wooden tables can be purchased from $25-$45 each.

Table lamps add warmth to the room and can be purchased

for under $40 each. Most psychiatrists expressed a preference for the table lamp over wall fixtures or floor lamps. More intimate, and uncluttered floor space were two reasons.

Consultation room

The consultation room of the psychiatrist is the most important room in his office. Here is where the bulk of the practice time is spent. Carpeting was suggested, here as well as in the waiting room, by respondents.

A desk, of course, is needed. The price of the desk will depend upon the style, size, and the material. In general, the average price paid for a desk, according to our survey, was $150. But, this figure varied from $50 all the way to $500. One point: the desk should be large enough and contain enough drawer space for the many items the psychiatrist will want at his fingertips.

Perhaps even more important than a desk are the chairs for patients and for the physician. Your chair should be picked primarily for your comfort.

"It will be your best friend and will be close to you for many years," said one doctor. Try before you buy. Good chairs can be expensive. According to psychiatrists, the chair they thought best, in some cases, cost as much as $250.

In choosing a desk lamp, care should be given that the light is reflected downward, not into the patient's eyes. A good desk lamp can cost anywhere from $25 to $50.

Bookcases can bring color into the consultation room; also, they will add to some patients' confidence in the doctor. Bookcases can be purchased as a unit. The price quoted may be $75 or $100. They can be custom built to fit odd-sized wall areas.

Couch

The couch, of course, is an important piece of furniture in the psychiatrist's consultation room. There are many types seen in various offices, but in general are comfortable, have a headrest arrangement, either built in, or a pillow type arrangement. The material is usually leather or plastic; each is attractive but also easily maintained. The cost of such a couch is from a minimum of $150 on up, depending on material and design.

Many psychiatrists surveyed had some sort of recording device in their consultation room, either for keeping records or for therapy. These machines are not expensive; a suitable one will

cost anywhere from $100 to $200. Tape was considered superior to wire by all responding psychiatrists.

Some psychiatrists have an examining room or treatment room. This room serves two purposes. The first is that many psychiatrists combine a psychiatry practice with neurology and require a table for examinations. Others prefer a second room for electroshock therapy, permitting the patient to remain for a period after the "shock" without tying up the consultation room. A second room is not imperative, however, because many psychiatrists dispense shock treatment on the couch in the consultation room.

The examining room requires a basic table; a good examining table can be purchased new for from $250 to $800. Differences in price depend upon the type of materials, decorations, and extra features provided. Some psychiatrists, at the beginning, purchase an examining table secondhand.

A secondhand examining table in good condition usually can be purchased for under $100 and an adequate refinishing can be done for $25 to $30.

A treatment cabinet and a treatment stand may not be necessary right away. Perhaps money could be saved by using wall shelves or built in cabinets to serve the same purpose.

Examining lamps vary from as little as $15 to as much as $260 and more; the difference depending upon the source of light, type of illumination, and size.

Shock

The electric shock machine should be purchased new, most psychiatrists advised, since it is an electrical apparatus.

The cost varies with the type of machine, but 70% of the men surveyed spent less than $250.

A small sterilizer and a few syringes are needed for the office. The total cost of the sterilizer, syringes and drugs needed will probably be under $75.

Expense

The editors have attempted to give psychiatrist readers an overall view of the cost of outfitting the beginning office in psychiatry. Many items are omitted. Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price.

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure

was to be complete, including any items such as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may not need.

Some 20% of our group outfitted their offices for under $1500. More than half spent $2000 to $3000 on their initial office equipment. Thirty percent stated that their offices cost more than $3000.

Remember, prices have increased since the psychiatrists surveyed entered practice. Therefore, a rough estimate would indicate that the average office for the practice of psychiatry can be equipped for approximately $2500-$2600.

"There! You don't like me either!"

Medical Services On Time-Payment Plan?

For many years the American consumer has been accustomed to financing the purchase of various commodities and services on a periodic payment plan. Can physicians utilize this principle? Here's the way dentists have done it.

Joseph Arkin, C.P.A.

Would a pay-as-you-go medical service plan work? Could such a system be applied to the procurement of all medical services, including costly operations, to those who cannot presently afford these services in one lump-sum payment? Would such deferred payments be a deterrent to the inroads of socialized medicine?

The practice of medicine is unique and the application of commercial methods of financing debts would of course, be subject to modification. However, dentists in various parts of the country have been using a system of bank credit, installment payments for the past ten years.

One such plan is the Kanawha Valley (West Virginia) Dental Society Payment Plan which began operations in 1957 after a six-year study. Its purpose was to develop a financing mechanism which would make dental services available to "every honest and interested person." The Society was convinced that such a program would make more and better dental care accessible to many people in Charleston and the surrounding area, and believed that the responsibility for

its development belonged to the dental profession, not the state or federal governments.

The actual plan was set up this way: The Dental Society formed a committee which promulgated rules and regulations and was empowered to negotiate with a local bank for the rediscount of the patient's notes.

Loan arrangement

Under the contract, the patient completes his application form for a loan in the dentist's office. The application form is then forwarded by the dentist to the bank for processing and approval. After completing its investigation of the patient's credit, usually within 24 hours, the bank notifies the dentist. If approved, the dentist notifies the patient and arranges an appointment to start the work. A full review of the estimate is made, and the terms as to amount to be borrowed, length of time for payments, etc. are negotiated between the dentist and the patient. The patient then signs a promissory note, leaving date blank; this is protection for both dentist and patient: the dentist has a signed contract for the work, while the patient knows that the note does not become effective until the work is completed.

Most of the Dental Society plans now in operation do not place any maximum on the amount to be financed, but because of credit costs, a minimum is set in some communities.

Usually the patient does not have to make his first payment until 45 days from completion of his dental work.

After the dental work covered in the loan application has been completed, the bank purchases the note from the dentist, paying him 98 percent of his bill and depositing the remaining 2 percent in a loss reserve fund maintained in the name of the society. All losses on uncollectible loans are charged against the reserve fund. The bank reserves the right to take this action without first submitting the note to the judgment of the court or taking other steps to collect the overdue balance. However, in actual practice, the bank does make an effort to collect, and there is an informal agreement that the bank's representatives will discuss all defaulted notes with the secretary of the payment plan committee before charging them to the loss reserve fund.

In the event that the reserve fund reaches a level considered more than adequate for guaranteeing payment of outstanding

notes, the discount rate may be lowered or credit restrictions relaxed so that more people will be able to take advantage of the total payment plan.

Kanawha Valley's is a nonrecourse plan (the dentist cannot be held responsible for his patient's defaulted notes), but under the terms of the agreement, the dentist warrants that each note is genuine and that it constitutes his entire agreement with the patient. Furthermore, he agrees to furnish a "completed services form" as part of the note when he presents it to the bank for payment.

Results

With this background let us examine the results of the plan as compiled by the United States Department of Health, Education and Welfare (Public Health Service Unit).

1. The average loan was for $211.66; lowest $105, and the highest $530.

2. Only one note was in default during the first year of the plan.

3. More women than men used the plan.

4. Persons who had the largest families tended to make more use of plan, and had the biggest notes.

5. Families with principal wage earner having income of under $300 monthly accounted for 24.4% of persons using plan; $300 to $499 accounted for 48%, and over $500 for 27.6%.

Dentists who refused to participate in the plan gave as principal reasons:

- Satisfied with own system of financing care.
- Believe patients would resent plan.
- Too much trouble to handle paper work.

Those dentists who did participate gave these reasons for doing so:

- Eases payments for patients.
- Does not disrupt present financial arrangements.
- Patient gets better and *more medical service.*
- Dentist able to perform work more efficiently.
- Assures dentist of payment on time.
- Reduces credit losses.
- Reduces overhead costs for bookkeeping and collection.
- Gives dentist advantage of having income available, not as accounts receivable.
- Increases practice by having patients have work done instead of putting it off.
- Assures a more pleasant relationship, since fee discussions

become unnecessary during progress of treatment.

Disadvantages

Listed as some of the disadvantages of the plan:

To the Dentist:

- Could create atmosphere of being too businesslike, too commercial.
- Might cause strained relations.
- Dentist pays for this service while he might now be in position to collect 100 cents on the dollar.
- Causes a certain amount of bookwork, (filing, forms, etc.).

To the Patient:

- Patient must pay interest charge.
- Patients who are poor credit risks may still not be able to get proper treatment.
- Recourse for poor work may not be available when having to deal with bank instead of dentist.

The Government report contained a volume of facts and figures which for the purpose of this article have been condensed into the pro and con citations.

However, general patterns do emerge:

1. Younger dentists tend to use the plan more than long-established dentists. This, because they are less able to provide their own financing.

2. Most of those who used the plan regularly said that it was an aid in the fulfillment of their professional obligation to perform service. They could perform with the full assurance of receiving payment.

3. Those who were infrequent users of the plan employed it primarily to get financing for bad credit risks.

4. Old timers tended to shy away, feeling that the professional relationship with the patient might be disturbed.

5. Some who did not participate felt that the only benefit was to the dentist's pocketbook—and that no other useful purpose was served.

With study and investigation, perhaps a plan could be formulated for the medical profession which would allow for medical service, tests, prolonged treatments, and still retain the doctor-patient relationship.

It has been argued that no person of moderate means should be forced to seek medical treatment at the risk of bankrupting himself, or applying for charity, and a person should be allowed to pay in a dignified manner. Perhaps this form of payment plan is an answer to this problem.

SPECIAL **RESIDENT PHYSICIAN** REPORT

The New Part III Examination

For house staff members who plan to take Part III of the examination of the National Board of Medical Examiners in June, here are some radical changes which have been made in the overall exam.

After what the National Board of Medical Examiners calls an "earnest two-year study," the Board has come up with a type and form of examination which it believes will

- provide a comprehensive test of a candidate's readiness to assume the role of physician in clinical practice
- permit evaluation of all candidates on a set of uniform criteria
- accommodate large numbers of examinees
- meet the technical requirements of objectivity, reliability and validity to evaluate the degree of clinical competence that a physician should have after one year of internship.

Clinical competence

The first step in this project was to obtain a realistic definition of the skills that determine clinical competence at the intern level. To a medical person, say a senior physician who has himself been through an internship and who has had continuing supervision of interns and residents, such a definition might appear to be a rather simple matter. But,

to arrive at a composite outline of the essential components of the internship experience, irrespective of local custom and university affiliations, was far from simple.

The method used was that known as the critical incident techniques. . . . This method consisted of obtaining from physicians throughout the country examples (incidents) illustrative of intern performance. By interviews and by mail questionnaires, senior physicians, junior physicians, and residents were asked to record clinical situations in which they had personally observed interns doing something that impressed them as examples of good clinical practice and, on the other hand, examples of conspicuously poor clinical practice.

A total of 3,300 examples of such incidents were collected from approximately 600 physicians.

Examples

A review of these incidents—divided about equally between "good" practice and "poor" practice — provides an extraordinarily interesting — and also a rather disturbing — description of what actually goes on during internship.

Among the most frequently reported examples of good clinical practice were the following:

- accurately recognizing the patient's condition from observation of clinical signs
- withholding the diagnosis until additional needed information was available
- correctly suspecting an obscure diagnosis despite the apparent obviousness of another diagnosis
- taking emergency action when indicated
- taking a history thoroughly, and performing a physical examination in an orderly, sequential manner.

In contrast to these, the most frequently recorded examples of poor or ineffective clinical practice included the following:

- prescribing antibiotics without first establishing the cause of the disease or checking drug sensitivity
- failing to consider other than the most obvious causes of symptoms and signs
- making a diagnosis with inadequate information
- prescribing medication with inadequate indication.

The large body of information resulting from the 3300 incidents was then reduced to manageable proportions. The incidents were summarized individu-

ally, grouped and classified. They fell into nine major areas of clinical performance:

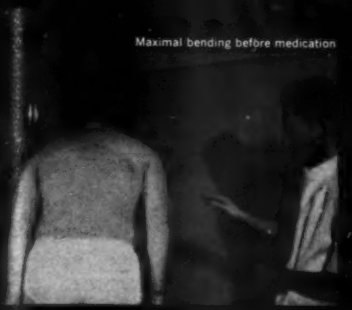
1. Competence in taking a history.
2. Skill and thoroughness in performing a physical examination.
3. Selection and understanding of appropriate laboratory procedures.
4. Diagnostic acumen.
5. Judgment in deciding upon appropriate care.
6. Judgment and skill in implementing care.
7. Competence of continuing care.
8. Effectiveness of physician-patient relationship.
9. Accepting responsibility for the welfare of the patient and for community health, on behalf of the hospital, and the medical profession.[1]

Exam aims

Therefore the examination which will be given in June will, to quote the Board, have the following aim:

1. To evaluate the degree of clinical competence that may be expected of an intern.
2. To test skill and perform-

"Fred, I'm prescribing a long rest."



Factual Clinical Data: Male patient with marked spasm of right lumbar region found even slight bending extremely painful. Fifteen minutes after administration of 10 cc. of ROBAXIN Injectable, spasm had disappeared and patient could bend without pain. Photographs used with permission of patient.

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ance—not factual knowledge *per se*.

3. Emphasis will be placed upon medicine as a whole rather than specific subject areas, such as the four major subjects that have in the past constituted Part III.
4. At least one hospitalized patient will be used for the examination of each candidate in order to provide an opportunity for testing skill in history taking, physical examination, diagnostic acumen, and clinical judgment.
5. The examiners will judge a candidate by direct observation of what he does, how he takes a history and performs a physical examination, rather than, as has so often happened in the past, quizzing the candidate apart from the patient and scoring him on the basis of what he says he has done.
6. Moving picture films, especially designed to test certain skills and characteristics, may be included in the test situation.
7. Standardized scoring forms and group testing will permit objective scoring of responses and will reduce the number of examiners and variability of their scoring.
8. The scoring of examinations will be done at the central office of the National Board by compiling marks recorded by examiners' and responses made by examinees.
9. The score required to pass the test will be a realistic attempt to disinguish between those qualified and those not considered to be qualified for certification by the National Board. *Presumably the percentage of failures will be higher than in the past* (Italics Own—ED.)
10. The Part III examination will be scheduled twice a year, probably in January and June. Since duration of training and level of competence are not necessarily equal, an individual candidate might take the examination during the internship year. The satisfactory completion of one full year of internship would, however, remain a requirement for certification by the National Board.[1]

1. The National Board Examiner, December 1960.

QUIET, PLEASE!

YOUR WIFE'S TALKING

SURVIVAL ON FIFTY DOLLARS A MONTH

"There must be a way to live happily and comfortably on fifty dollars a month. The only thing is—no one has found it. The result is that you don't live on this sum, you survive on it. Impossible? Of course it's impossible, but think of the challenge."

Elizabeth Beltran

The immediate problem facing you when you've picked the hospital where your husband will take his internship or residency is housing. Since your car is twelve years old and you get only three miles to the gallon of oil, you look for a place near the hospital.

The first place you look at is a dark damp three-room apartment over a poolroom. (There must be more apartments over poolrooms than over anything else.) There's a railroad running right behind it and the landlady smokes cigars. You retreat in horror when she suggests that you can have it for thirty dollars a month if you'll collect rents from the four taverns and the poolroom she owns. However, you smile and give her a civil goodbye. Three days and fifteen even worse places later (the cheapest was fifty-five dollars) you go back and take it.

Curtains

Now that you have the key, you and your husband look around the place to see what can be done to fix it up. The first thing you think of is a chain lock for the door. Next you note that the windows are ten feet tall and two feet wide which makes finding ready-made curtains impossible (your husband can't understand why this is so tragic). The door on the oven doesn't close and there's only one cupboard.

The "furnished" living room has a faded lavender carpet, the sofa is orange, and the springs that aren't lying on the floor are poking through the cushions. The base of the one lamp is a Zulu with a ring through his nose. (You pull on the ring to light it. It doesn't light. No bulb.)

The bedroom has no rug, but the brass bed looks like it will last a millennium or two and the mattress obviously has. The dresser is a three-drawer Victorian monstrosity with a cracked mirror hung above it, not quite centered.

Everything in the bathroom leaks.

The only thing to do at this point is to take your last five dollars and go out for dinner. Once you're away from it you'll realize that no place could really be that terrible and you'll be able to "fix it up."

Scrounge

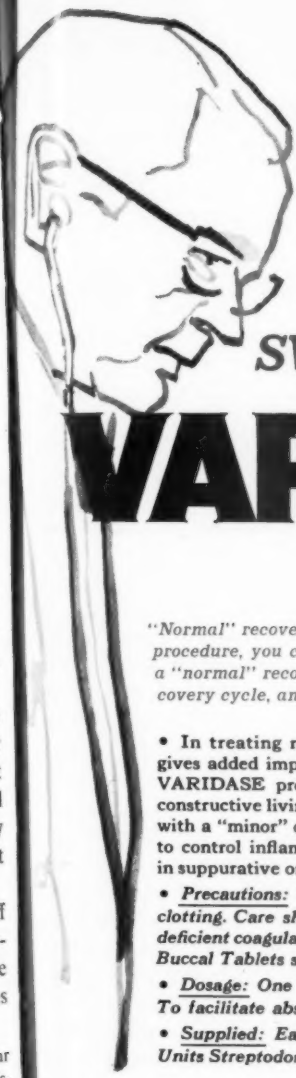
Now begins the scrounging. Think of everyone you know who has an attic. Your mother and your husband's mother probably have boxes full of things that "might be useful some day." The day has come.

Great - uncle Harry's wedding picture *will* cover a crack in the plaster and he looks enough like Teddy Roosevelt to fool anyone. And it's completely unnecessary to worry about whether or not anything will "go" with the sofa and carpet. What could?

If you have some handsome wedding presents, such as silver and china put a few pieces out where you can see them. It'll serve to remind you that poverty is only relative (whatever that means).

In the process of scrubbing off the ten inches of grime that covers everything, you may come across a number of little creatures

ABOUT THE AUTHOR The author is married to a resident in his second year of anesthesiology at the Veterans Hospital, Wood, Wisconsin. They have three small children.



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• ***Precautions:*** *VARIDASE has no adverse effect on normal blood clotting. Care should be taken in patients on anticoagulants or with a deficient coagulation mechanism. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with antibiotics.*

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that hop, slide, or slither. Fainting won't faze them, however much you may desire to, but bug spray will. You'll probably never completely win the battle but you'll have the satisfaction of fighting the good fight. And there's always the hope that they'll find a place down the street where they'll feel more at home.

Finally, after a month or so of working twelve hours a day, you'll have done as much as you can. The sofa is still lumpy in spite of your husband's handiwork on the springs (I do wish they'd give a course on "Treatment and Repair of Household Lesions" in medical schools) and you have to tape the oven door shut whenever you use it. Five pots of ivy and African violets not only cover the initials carved into the window sill but give you something else to look at besides great-uncle Harry.

Food budget

The main problem now seems to be the food budget. You try vainly to remember the last time you tasted rib roast and you wonder if your mother would think it odd if you asked for one for your birthday.

There are certainly at least 999 ways to cook hamburger but some of those recipes are not too practical. If you add five dollars worth of mushrooms, sour cream and other goodies to fifty cents worth of hamburger you're going to be pretty hungry by Saturday. The same goes for stews and pot roasts. Of course, there's always

pigs knuckles, kidneys, and soup. I had to give up making soup because I could never make just a little of it. By the time I was finished preparing it, I had buckets of it all over the kitchen. Since I ate alone 90 percent of the time, it meant I had to consume 90 percent of the soup. After a day or two, I sloshed whenever I moved. In the interests of gastronomic serenity I gave it up.

You will find such a mundane job as doing the laundry unusually exciting. First, a call to the railroad to find out what times the trains go by. Next, check to find out what time your neighbor shakes her rugs. Then inquire as to the time the coal truck delivers. Of course, you'll discover it's impossible to avoid all these hazards, so you'll learn

to become resigned to a less than sterile wash.

Our landlady provided us with a washing machine. Only a few years older than you are, the wringer works only when its been whacked seven times with your left shoe (for some reason the right one doesn't do the job).

The only light supplied in the basement is a twenty watt bulb on the other side of the room from the machine, so you use a flashlight to find the socks and handkerchiefs. Scratching noises from the corner behind the furnace *might* be mice, but a few bars of "Tenting Tonight" whistled loudly will keep them on their own side of the basement.

Duty days

It's smart to take a few glances at your husband's picture now and then so you'll be able to recognize him when he does get home. The hours an intern or resident works are carefully arranged so he'll never be home on birthdays, anniversaries, or holidays. If you think seven is a fine hour for breakfast and are addicted to six o'clock dinner hours, you obviously did not grow up in a doctor's house.

Of course there are days "off." They provide a fine opportunity for balancing the budget. The method most commonly used is filling out loan applications. Figure out how much you absolutely have to have and divide by 10. Banks operate on the principle of allowing enough so you won't starve to death before you have a chance to pay it back.

Family visits

Whether you live near home or not your families will pay you at least one visit. In anticipation of the event you will have scrubbed everything three times and made twelve or thirteen changes in the menus planned for the big event. You want your mother to know that in spite of the fact you hung all your clothes on the closet floor at home you really have changed. And you want to reassure your mother-in-law that regardless of all your husband's shortcomings you're not systematically trying to poison him.

When your mother arrives she

will have in mind all those letters you wrote about "fixing up the apartment." Somehow you neglected to mention the poolroom and the railroad track. She will also be thinking of Dr. Brown at home who lives on Elm Street in a lovely two-story brick house. The result is that when she has viewed your present surroundings she'll burst into tears. Your father will save the day by recalling that Dr. Brown was 35 when he bought that house.

Your in-laws will be a little discouraged to discover that after years of giving up vacations, new cars, and never repainting the house so that they could put their son through medical school, he still can't earn a "decent" living. But once he walks in the door with that little black bag and starts talking about opening an office in the Bank Building someday, they'll feel it was worth every cent (and when your father-in-law eats two pieces of pie and your mother-in-law asks for the recipe, you'll know you worried for nothing).

Inevitably, there will be a problem relative, most likely a cousin passing through town on his annual circuit of the race tracks. After you've finally dragged him out of the poolroom and served him dinner he will

expound for three or four hours on medicine. He will announce that hospitals exist for the sole purpose of getting as much money as possible from the poor. He knows for a fact that all doctors want to do is get rich and that they don't care whether their patients get well or not. He's heard those expensive drugs that doctors prescribe are nothing but sugar and water and are used to hide the fact that doctors don't know anything.

Cousin swears he owes his own excellent health to a vitapath who gives him (for ten dollars a bottle) Xtronium 12, which when rubbed on the scalp sends healing rays through the body. So far it's cured Cousin of cancer, hemorrhoids, and hiccups . . . but not running off at the mouth.

There's really nothing to do at a time like this but to remember that Cousin will be gone first thing in the morning so he can make it to the track in plenty of time for the daily double.

No doubt you'll give a lot of thought to starting your family but one long look at the bank

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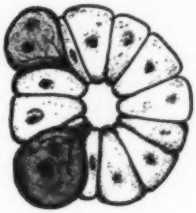

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balance and the size of your apartment tells you that it's out of the question.

Babies

This is about the time you'll discover you're pregnant. There's really nothing to fret about because Junior will never remember that he spent his first few months sleeping in a dresser drawer clad in hand-me-down clothes, and you'll be two states away from that poolroom by the time he's big enough to push those swinging doors.

Besides, if people had babies only when they could afford them, think of the obstetricians and pediatricians who would be looking for jobs as golf pros.

Dry ground

Into each life some rain must fall. And though an occasional shower isn't too bad a downpour can be depressing. It probably started when the wringer wouldn't work no matter how hard you whacked it. Your husband hasn't been home for three nights and has just called to tell you that he has to cover the emergency room tonight because Jim Smith has the measles and is off the duty list. You're five months pregnant and know positively that you look repulsive. The cake you baked fell, and the sofa springs are popping through the cushions again. Before you're completely drenched look for dry ground. Visit another medi wife or see a funny movie or take five dollars out of the baby fund (he really doesn't need a musical training seat anyway) and buy a pair of purple and orange maternity shorts. If you can't fight it—laugh it to death. After all, stipends are going up. Next year you'll probably be in the $90 a month bracket . . . if you survive the present period of $50 per, that is . . . and then you'll really be living it up!

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1. No dilution 2. No mixing 3. No waiting . . . in stable solution ready-to-inject with small-bore needle. . . . Plasma steroid levels are evident within 5 minutes after injection by any route . . . intravenous, intramuscular or subcutaneous.

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DOSAGE: The usual dose of Injection HYDROCORTONE Phosphate in emergency situations is 100 to 250 mg. depending upon the severity of the condition. For additional information see package circular.

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Additional information is available to physicians on request.

MSD MERCK SHARP & DOHME, Division of Merck & Co., INC., West Point, Pa.

48 More Contest Winners on page 69!

A **Resident Physician** MONTHLY FEATURE

Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 170.*

1. An early and constant sign in lead poisoning is:

A) An increase in the density of the distal portion of the ulna.

B) An increase in urinary coproporphyrins.

C) An increase in the serum lead value.

D) The appearance of gingival discoloration.

E) The appearance of basophilic stippling on the stained smear of peripheral blood.

2. The etiology of functional uterine bleeding is probably an excess of:

A) Hydrocortisone.

B) Estrogens.

C) Progesterone.

D) Gonadotropic hormones.

E) Thyroid hormones.

3. The sebaceous glands of the areola of the breast which hypertrophy during pregnancy are called the:

A) Glands of Montgomery.

B) Pregnancy nodules.

C) Glands of Douglas.

D) Glands of lieberkuhn.

E) Secondary areola.

4. In pregnancy, chorionic gonadotropin reaches its highest levels at:

A) 1-3 weeks.

B) 4-6 weeks.

C) 8-10 weeks.

D) The second trimester.

E) Term.

5. Ovulation in the normal menstrual cycle usually occurs between the :

...does she know that only **you** can help?

Many patients are unaware that their physician is the best source of contraceptive advice. Your prescription for Ortho-Gynol or Ortho-Creme with a diaphragm assures her the best available contraceptive protection. Accurate tests* for spermicidal potency, as well as years of clinical use, demonstrate that ORTHO contraceptive products are instantaneously spermicidal. The choice between Ortho-Gynol and Ortho-Creme is one of individual esthetic preference.

Ortho-Gynol® vaginal jelly

Ortho®-Creme vaginal cream

*The spermicidal potency of all ORTHO products is controlled by the **Titration Test** and the **Sander-Cramer Test** which more closely duplicate vaginal conditions during coitus than other tests.

WHENEVER A DIAPHRAGM IS INDICATED

Ortho

A) 4th and the 8th day.
B) 8th and the 12th day.
C) 12th and the 16th day.
D) 16th and the 20th day.
E) 20th and the 24th day.

6. Of the following, the most common site for metastases from carcinoma of the breast is the:
A) Brain.
B) Liver.
C) Mediastinal nodes.
D) Ovaries.
E) Other breast.

7. Postbulbar duodenal ulcers differ from ulcers of the cap especially in their greater tendency to:
A) Hemorrhage.
B) Cause intractable pain.
C) Perforate.
D) Cause pseudodiverticula.
E) Be refractory to dietary treatment.

8. During a thyroidectomy, as the external jugular vein is divided cardiac embolism develops. What should be done first?
A) Hold the vein closed and turn the patient on his left side.
B) Raise the head of the table and leave the vein open.
C) Quickly find and ligate the open vein.
D) Quickly start and force blood transfusion.
E) Apply artificial respiration while administering oxygen.

9. The hairs in the vestibule of the nose are called:
A) Olfactory hairs.
B) Telogen hairs.
C) Cilia.
D) Stub hairs.
E) Vibrissae.

10. The acquired type of choanal atresia is most likely to be located:
A) At the level of the inferior turbinate.
B) At the level of the middle turbinate.
C) In the pharyngeal region.
D) Anteriorly.
E) In Kiesselbach's area.

11. In a subject with a healing tuberculous lesion, the monocyte: lymphocyte ratio tends to:
A) Fall.
B) Approach zero.
C) Undergo no change during drug therapy.
D) Rise.
E) Undergo diurnal variation.

12. Of the following diseases the only one in which a monocytosis is generally regarded as an unfavorable prognostic sign is:
A) Pneumococcal pneumonia.
B) Malaria.

C) Kala-azar.
D) Tuberculosis.
E) Agranulocytosis previously thought to be in the recovery phase.

13. A common cause of death in Marfan's syndrome is:
A) Congestive heart failure.
B) Electrolyte imbalance and shock.
C) Hepatic failure.
D) Uremia.
E) Gastrointestinal malignancy.

14. In the nephrotic syndrome there is an increase of:
A) Hemoglobin.
B) Gamma globulin.
C) Beta-lipoprotein.
D) Blood glucose.
E) Serum albumin.

15. The Lisfranc amputation of the foot is:
A) A subastragaloid disarticulation.
B) An amputation through the middle third of the leg.
C) A tarsometatarsal disarticulation.
D) A mediotarsal disarticulation.
E) An amputation just above the malleoli.

EQUANIMITAS

What's the Doctor's Name?

Historian, editor and translator, he was the leading English authority in the twentieth century on the history of medicine and science.

He was a Fellow of the Royal College of Physicians and, at his death, Professor Emeritus of the History of Medicine at the University of London. In 1931 and 1932 he was visiting professor at the University of California and had lectured previously at the Johns Hopkins University. He was a Doctor of Literature as well as a Doctor of Medicine and held an honorary degree of Doctor of Science from Oxford University. He was president of the British Society for the History of Science from 1946 to 1948 and of the International Society for the History of Science from 1947 to 1950. He was co-holder of the latter society's Sarton Medal with his wife.

Among his many writings are *Essays on the History of Medicine* (1924), co-edited with Dr. Henry E. Sigerist and presented to the pioneer medical historian Karl Sudhoff on his 70th birthday, *The Evolution of Anatomy* (1925), *From Magic to Science* (1928), *A Short History of Medicine* (1928) *A Short History of Biology* (1931), *A Short History of Science to the Nineteenth Century* (1941), *A History of Biology* (1950). He was one of the editors of the four-volume *A History of Technology*, published from 1954 to 1958, intended "to provide students of technology and applied science with some humane historical background for their studies." In 1959 he published *A Short History of Scientific Ideas to 1900*. He wrote many pamphlets and articles and translated writings of Galen on anatomy and da Vinci on the heart and circulation.

In 1953 a two-volume collection of essays on the evolution of scientific thought and medical practice was published in his honor.

He died at his home in Cornwall, at 83, on June 10, 1960. Can you name this doctor? *Answer on page 170.*

VIEWBOX DIAGNOSIS

(from page 29)

OSTEOPOIKILOSIS

There are multiple bony islands scattered in the medullary cavities. These are simply compact bone ectopically found in the medullary cavities.

●

MEDIQUIZ ANSWERS

(from page 164)

1(B), 2(B), 3(A), 4(C), 5(C), 6(C), 7(A), 8(A), 9(E), 10(C), 11(A), 12(D), 13(A), 14(C), 15(C).

●

WHAT'S THE DOCTOR'S NAME

(Answer from page 169)

CHARLES SINGER

●

RESIDENT RELAXER

(puzzle on page 21)